Navigation Instructions

Maryland Higher Education Commission

Stage 1 Application

Meritus School of Osteopathic Medicine

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Meritus School of Osteopathic Medicine

MHEC Stage I Application for Institutional Approval to Operate

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Meritus Health
11116 Medical Campus Road
Hagerstown, MD 21742
Phone 301-790-8000

SENT VIA EMAIL TO THE MARYLAND HIGHER EDUCATION COMMISSION

September 14, 2022 EMAIL DELIVERY

Office of Academic Affairs
Maryland Higher Education Commission
6 N. Liberty Street, 10th Floor
Baltimore, MD 21201

To Whom It May Concern:

RE: MERITUS SCHOOL OF OSTEOPATHIC MEDICINE, HAGERSTOWN, MD

Meritus School of Osteopathic Medicine ("MSOM" or "institution"), to be located in Hagerstown, Maryland is presenting their Stage I Application for an In-State Degree-Granting Institution License pursuant to all rules and standards set forth by the Maryland Higher Education Commission (MHEC).

MSOM believes that with the application process that the MHEC has developed for all institutions, it will allow MSOM to demonstrate the research, time, effort and investment it has made to offer programs and coursework that will abide by all rules and regulations set forth by MHEC while preparing its students for careers in their chosen fields. The institution wants to demonstrate full compliance with all MHEC standards and will be fully available to answer any questions or provide clarity to any documents or processes that the MHEC staff may have in their review of the application.

The vision of the institution is set forth to provide students with the opportunity to attend a respected center for academic and practical learning under the overall guidance and leadership of highly qualified institutional leadership. The founding dean, Dr. Paula Gregory, brings tremendous experience including serving as the founding dean of the Kansas City University School of Medicine and Bioscience Joplin campus, the Chair of primary care at California Health Sciences University, and associate editor of the Osteopathic Family Medicine journal. MSOM's president, Maulik Joshi Dr.P.H, currently serves as the president and CEO of Meritus Health and is a commissioner for Maryland's HSCRC. He is also adjunct faculty at the University of Michigan School of Public Health in the Department of Health Management & Policy where he teaches annually.

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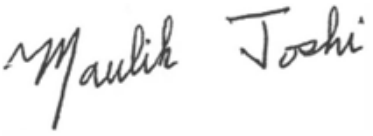
Phone 301-790-8000

The institution believes that the opportunity to offer a MHEC authorized, Doctor in Osteopathic Medicine ("D.O") degree program would benefit both students and patients in Maryland, across the United States and around the globe in the various medical fields for which training will be provided.

The entire MSOM staff and faculty look forward to providing MHEC with any additional information that you may need in review of our institution. If you need any further assistance in regard to MSOM's application, please do not hesitate to contact Mr. Dave Lehr at david.lehr@meritushealth.com or by phone at (301) 790-8215. You may also contact Mr. Chris Georgetti at G@SandGConsult.com or by phone at (407) 257-8568 as our institution has retained Santoro and Georgetti Postsecondary Educational Consultants to guide our institution through the MHEC Licensure Application process as his firm is authorized to speak for and present information to the MHEC on behalf of the institution.

Sincerely yours,



President and CEO
Meritus Health
Maulik.Joshi@meritushealth.com

Cc: Chris Georgetti, Co-Founder and CEO
Santoro and Georgetti Postsecondary Educational Consultants
Orlando and Tampa, Florida

STAGE ONE APPLICATION

MARYLAND HIGHER EDUCATION COMMISSION

Stage One Application for Initial Approval
as an In-State Degree-Granting Institution

Name of Proposed Institution

Meritus School of Osteopathic Medicine

Mailing Address of Proposed Institution

Meritus School of Osteopathic Medicine (Proposed)
Meritus Health
11116 Medical Campus Road
Hagerstown, MD 21742

If a specific facility is yet to be identified, please provide as a minimum, the county or city in which you plan to operate.

Person to Contact For this Application:	Dr. Paula Gregory
Title:	Founding Dean & Chief Academic Officer
Organization:	Meritus School of Osteopathic Medicine
Mailing Address:	11116 Medical Campus Road Hagerstown, MD 21742
Telephone Number:	301-790-8215
Email:	Paula.Gregory@meritushealth.com

Office of Academic Affairs
Maryland Higher Education Commission
6 N. Liberty Street, 10th Floor
Baltimore, Maryland 21201
(410) 767-3300

acadprop.mhec.@maryland.gov

STAGE ONE APPLICATION

Under the *Code of Maryland Regulations* (COMAR) 13B.02.02.06, there are two stages that a prospective institution shall complete before the Secretary of Higher Education may grant institutional approval to operate. The application process may take up to six months after the receipt by the Maryland Higher Education Commission of a completed Stage One and Stage Two application. The prospective institution shall complete the first stage before it may start the second stage.

(a) A prospective institution shall provide an initial, **Stage One Application** to the Secretary of Higher Education which requires:

(1) A demonstration of a compelling regional or Statewide need and demand to initiate specific academic degree programs in a specific geographical region of the State (see COMAR 13B.02.02.05).

(2) Evidence of adequate financial resources to establish and maintain and institution of higher education as provided in COMAR 13B.02.02.07.

(3) Additional information as the Secretary may require (see COMAR 13B.02.02.06F).

(4) The required Application Fee (see below).

(b) Upon submission of the Stage One Application it will be distributed to all higher educational institutions in the State for a thirty-day comment period. The Secretary shall consider all comments and objections received prior to making a final Stage One decision.

(c) The Secretary may ask the applicant for additional information in response to the comments and objections.

(d) The Secretary shall then make public the final decision on the Stage One proposal at a regularly scheduled meeting of the Maryland Higher Education Commission. If the Stage One proposal is approved, the institution shall proceed to complete and submit a separate follow-up, Stage Two Application.

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This questionnaire, properly completed with the supporting documentation and a completed page one cover sheet, shall serve as the Stage One Application for approval to operate in Maryland under the *Code of Maryland Regulations* (COMAR) 13B.02.02.

I. SUPPORTING DOCUMENTATION.

☒ **Application Fee**. (COMAR) 13B.02.02.06D

The institution shall submit a non-refundable application fee in the amount of (a) $7,500 for up to two degree programs and (b) an additional $850 for each degree program over two

programs. the institution's check should be made payable to: Maryland Higher Education Commission.

☒ **Certification.**

I hereby certify that the answers given in this application and its attachments are accurate and complete and further agree to comply with the Annotated Code of Maryland and State regulations governing the minimum requirements for degree-granting institutions operating in Maryland (COMAR 13B.02.02).

September 14, 2022
Date

Signature of Chief Executive Officer

II. APPLICATION QUESTIONAIRE.

1. Proposed Programs. A detailed and accurate description of the prospective institution's proposed programs and operations shall be provided and will include: all degree and certificate programs to be offered; a description of the objectives of each degree and certificate including the modes of instructional delivery; a description of the student population to be served; the curriculum for each program to be offered; and the nature of faculty and resources required to support the programs. See COMAR 13B.02.02.06E(d).

✓ **INSTRUCTIONS. Please enter the requested information in the spaces provided below, or create an attachment (labeled "A-1: Programs") to this application with your responses to the following questions:**

(a) Provide a complete list of all the proposed programs and certificates to be offered. For each of these programs provide the following information:

(1) the full title of the program;
(2) all areas of Specialization;
(3) the degree or certificate to be awarded;
(4) the total number of credit hours (semester or quarter);
(5) the mode of instructional delivery;
(6) the curricular outline; and
(7) the educational objectives of the program.

The institution, Meritus School of Osteopathic Medicine (referred throughout this application as "MSOM" or "institution"), intends to offer as its initial program, the Doctor of Osteopathic Medicine program which will result in a student being awarded an earned "DO" degree. No other program or degree will be offered initially as the institution intends to demonstrate to MHEC that is uniquely positioned to be a leading

institution in the state of Maryland specializing in offering this single program at the outset.

1. **Full Title of the Program:** Doctor of Osteopathic Medicine
2. **Areas of Specialization:** Not Applicable
3. **Degree to be Awarded:** Doctor of Osteopathic Medicine (DO)
4. **Credit Hours:** 158 (Semester hours)
5. **Mode of Instructional Delivery:** Residential

5. Mode of Instructional Delivery (additional detail):

The DO program will be a four-year, semester-based program requiring 158 credit hours. The mode of instructional delivery will be team-based, in-person learning which will consist of an initial exam assessing learner styles through the Individual Readiness Assurance Test ("IRAT") or similar assessment tool, followed by facilitated symptom and case-based discussion and a post team test.

First and second year students are trained in classroom and laboratory settings. Faculty lectures (live and recorded) will be used throughout the program. These lectures will be integrated alongside reading assignments as students will learn from the system approach, translating from normal to abnormal across each system (i.e., circulatory system, digestive system). Attention will be placed on common disease states as well as abnormalities, and this will be elicited through the molecular, cellular and system levels. Students will be given a weekly system-based case and a weekly discussion of key points by system. Each case will conclude with end-of-case presentations by all groups. Group discussions will be monitored by Faculty Facilitators who will ensure appropriate process and progress.

To enhance the student engagement and learning, the institution will include dedicated labs as follows:

Anatomy and Imaging Laboratory: Integration of structure and function throughout all systems over the preclinical years. Students will virtually dissect and study the human body and its systems using the most advanced simulation technology available for medical education. Student activities will align anatomical with radiological presentation (e.g., CTs, MRIs, ultrasound).

Skills Laboratory: Objective Structured Clinical Exam (OSCE) on standardized patients. The clinical laboratory will include hands-on experience on peers, mannequins, and standardized patients.

Osteopathic Manipulative Medicine (OMM) Laboratory: Students will develop osteopathic practice skills in the OMM laboratory throughout their preclinical years. Students are taught to give a complete osteopathic examination, which includes the musculoskeletal system, range of motion, palpatory skills, and specific treatment techniques.

Longitudinal courses include Osteopathic Manipulative Medicine ("OMM") for hands on system-based instruction, clinical laboratory course for key questions and examination of the human body and interprofessional education.

Research is an additional required course that includes the team-based learning module with a student group assigned to a faculty mentor to guide them through community-based research with an emphasis on rural population health.

Student learning and engagement will be enhanced by significant investments in technology utilized throughout the program. One example will be MSOM's virtual anatomy lab, to feature an augmented reality platform like HoloAnatomy™, which has been used very successfully at other leading colleges of medicine. Students will also leverage technology through simulation labs that will include high-fidelity mannequins that will be used to simulate various scenarios.

Third- and fourth-year students are trained in clinical settings. Clerkships in the third and fourth years of the medical education continuum provide for a variety of clinical exposures and experiences, from preceptorships in physicians' private practices to serving as team members in a tertiary care hospital. There will be 13 required and 6 elective rotations. An emphasis will be placed on clinical experiences in rural, underserved communities. MSOM will prioritize rotations across the Meritus Health System, Washington County, MD and the surrounding region.

Students will be trained in rural focused, underserved areas in the region including the Meritus Health System. Core clerkships will begin on campus and the clinical rotations will be supported by linking back to the MSOM curriculum. There will be discipline related cases, grand rounds and other opportunities to remain connected to the area.

6. Curricular Outline

The following outline details the classes, credits, and course progression:

	Course Number	**Course Name**	**Credits**
Year One			
OMS I - Fall	OM 1000	Foundations of Biomedical Sciences	3
OMS I - Fall	OM 1010	OMM Principles and Practice I	3
OMS I - Fall	OM 1020	Physician Skills I	3
OMS I - Fall	OM 1030	Interprofessional Education	1
OMS I - Fall	OM 1040	Research	1
OMS I - Fall	OM 1050	Organ Systems I	9
OMS I - Spring	OM 1011	OMM Principles and Practice II	3

6. Curricular Outline (continued)

	Course Number	Course Name	Credits
OMS I - Spring	OM 1021	Physician Skills II	3
OMS I - Spring	OM 1031	Interprofessional Education	1
OMS I - Spring	OM 1041	Research	1
OMS I - Spring	OM 1051	Organ Systems II	12
Year Two			
OMS II - Fall	OM 1012	OMM Principles and Practice III	3
OMS II - Fall	OM 1022	Physician Skills III	3
OMS II - Fall	OM 1032	Interprofessional Education	1
OMS II - Fall	OM 1042	Research	1
OMS II - Fall	OM 1052	Organ Systems III	12
OMS II - Spring	OM 1013	OMM Principles and Practice IV	3
OMS II - Spring	OM 1023	Physician Skills IV	3
OMS II - Spring	OM 1033	Interprofessional Education	1
OMS II - Spring	OM 1043	Research	1
OMS II - Spring	OM 1053	Organ Systems IV	12
Year Three			
OMS III - Fall	OM 3000	Introduction to Clinicals	4
OMS III	OM 3001	Family Medicine	4
OMS III	OM 3002	Internal Medicine – Hospitalist	4
OMS III	OM 3003	Internal Medicine/Subspecialty Clerkship	4
OMS III	OM 3004	General Surgery Clerkship	4
OMS III	OM 3005	Surgical Subspecialty Clerkship	4
OMS III	OM 3006	Pediatrics Clerkship	4
OMS III	OM 3007	OB/GYN Clerkship	4
OMS III	OM 3008	Psychiatric Clerkship	4
OMS III	OM 3010	OMM	3
Year Four			
OMS IV	OM 4010	OMM	3
OMS IV	OM 4001	Emergency Medicine	4
OMS IV	OM 4002	Rural & Underserved Medicine I	4
OMS IV	OM 4003	Rural & Underserved Medicine II	4
OMS IV	OM 4004	Elective Clerkship I	4
OMS IV	OM 4005	Elective Clerkship II	4
OMS IV	OM 4006	Elective Clerkship III	4
OMS IV	OM 4007	Elective Clerkship IV	4
OMS IV	OM 4008	Elective Clerkship V	4
OMS IV	OM 4009	Elective Clerkship VI	4
		TOTAL CREDITS	**158**

Additional Detail on Curriculum:

The curriculum outline has been designed to begin with foundational areas of study and coursework involving anatomy, physiology, and microbiology concepts for the initial two months. Next, six-week coursework and areas of study in communication, case-based labs, psychiatry, musculoskeletal and skin, followed by neurology and each subsequent system to follow for the first and second years as discussed in 5. Mode of Instructional Delivery, above. The first two years of instruction will be classroom and lab based while the third and fourth year will be based in clinical settings.

The institution's curriculum will include interprofessional activities covering topics such as intellectual disabilities, domestic violence, child abuse, substance abuse, and jurisprudence to name a few needed areas of society. The institution will also have community-based research with the first six (6) months of instruction centered on training i.e., Collaborative Institutional Training Initiative ("CITI"), creating a question, and abstract, materials and methods, creation of the question to be studied, MLS style bibliography using primary source verification, will be the underpinnings of the topics to be researched. The questions will be designed to learn about the health needs of the community and how to impact those disparities in a positive way. The Meritus Health system has created a wealth of opportunities to style a question for our rural population that links to health care disparities and the students will be mentored in teams to move through the project with these issues as a primary focus.

7. Educational Objectives

The educational objectives of the Meritus School of Osteopathic Medicine will be to prepare students to become qualified osteopathic physicians, prepared for entry into the practice of medicine within postgraduate training programs. MSOM will prepare future generations of physicians who are professionally accomplished, socially responsible and community oriented. The program spans four academic years, with the first two years in a pre-clinical phase and the last two years in a clinical phase. Specific objectives:

- Compassionate Patient Care
- Professionalism
- Knowledge for Practice
- Community and Population Health
- Practice-Based Learning and Improvement
- Interpersonal and Communication Skills
- Systems-Based Practice
- Interprofessional Collaboration
- Personal and Professional Development
- Knowledge of Research Processes and Application

Students are assessed throughout the curriculum on their learning progress of the core competencies. These are integrated into the programmatic learning objectives and students are required to demonstrate reasonable competence in the milestones as well as professional assessment at the completion of the program. Upon successful completion, these will signify that the graduate demonstrates readiness for caring for patients in a postgraduate training program under adequate supervision.

(b) Describe the student population which each program serves.

With the institution initially seeking MHEC approval for the DO program offering, graduates of colleges and universities that meet the various admissions requirements to enter medical school would be the population served. In the institution's research it has found that nationally, less than 10% of applicants are accepted into medical school.

National admissions rates indicate that there will be a large number of qualified applicants that would be acceptable for Meritus School of Osteopathic Medicine. The institution will actively seek students for MSOM who have ties to the state of Maryland and desire to practice community-based medicine for the DO program to enhance the underserved areas of Maryland and the region surrounding Washington County.

Meritus Health retained Tripp Umbach, an independent, third-party consulting firm specializing in medical school feasibility studies, to assess the feasibility of the proposed MSOM to analyze and independently assess the possibility of an osteopathic medical school in Hagerstown, Maryland. Tripp Umbach completed a report dated September 2022 ("Feasibility Analysis") which can be viewed as **Exhibit – Feasibility Analysis**.

Please see **Feasibility Analysis page 56** which highlights 2021 osteopathic medical school applicants totaling 27,277 compared to a total of 8,516 matriculants. These applicants submitted 243,565 individual school applications and the matriculants submitted 88,684 individual school applications.

Please see **Feasibility Analysis page 60** to view the number of applications for the 2021 academic year for each osteopathic medical school. Every osteopathic medical school received more than 1000 applications in 2021.

(c) Describe the nature of the faculty and resources (library, facilities, equipment) that will be required to support each of these programs.

The institution will create a learning environment that includes a substantial investment in not only the facility, faculty and supported resources, but also an investment that will benefit students, graduates and supported patients throughout Maryland, the United States and globally for decades to come. The goal of MSOM is to produce quality medical professionals who are appropriately trained to adhere to the

standards that a Doctor of Osteopathic Medicine would be expected to uphold in performing in the role of patient care.

This investment will result in the construction of a student learning environment that will reside inside of a brand new 190,000 square foot building on the Meritus Health campus. It will include classrooms for students, simulation and standardized patient labs, additional labs for OMM practice along with a vast array of online and physical collections of learning resource and library materials in accordance with COCA accreditation standards.

MSOM will also include a student gym for wellness and exercise, a cafeteria for staff, faculty and students, a full conference center capable of hosting gatherings of 1000 people, along with multiple study rooms for student learning. MSOM is also committed to facilitating construction of student housing on the Meritus campus that will allow for a true university-like student experience.

2. Educational Need. Before the Commission may evaluate an institution's readiness to operate or award new degrees in the State, the institution shall present evidence demonstrating the educational need to establish operations, offer programs, and award the degrees in question within the State. See COMAR 13B.02.02.05.

✓ **INSTRUCTIONS. Please enter the requested information in the spaces provided below, or create an attachment (labeled"A-2: Educational Need") to this application with your responses to the following questions:**

(a) **For each program** proposed in Section One above, what **"critical and compelling"** Regional or Statewide (Maryland) need and demand do these programs meet? [COMAR 13B.02.02.05C] In responding to this question provide documentation as indicated below:

(1) If the proposed programs serve an occupational need, present data projecting market demand and the availability of openings in the job market to be served by these new programs for which the institution is making application. This information will include:

(A) workforce and employment projections prepared by the federal and State governments:
(B) the availability of graduates in the State or region;
(C) marketing studies done by the institution or others;
(D) data from prospective employers on education & training needs and the anticipated number of vacancies expected over the next 5 years,
(E) material from professional and trade associations; and
(F) consistency with the Maryland State Plan for Postsecondary Education.

As a health system in the state, the Meritus Health team can attest from first-hand experience that the state of Maryland has an urgent and growing shortage of physicians. This shortage, which drives up the cost of rural healthcare through top-quartile physician wages, is in part a consequence of a shortage of medical education programs like the one proposed here. Please see **Feasibility Analysis page 4, Key**

Findings: Physicians are needed in rural Maryland due to the increased population and an aging physician workforce.

In terms of workforce and employment projections nationwide, the Association of American Medical Colleges ("AAMC") is predicting a shortage of up to 124,000 physicians by the year 2034[1]. Locally, the institution's own research through independent studies from 3D Health show that, in Washington County alone, there is currently a shortage of 52 physicians across all specialties. Meritus Health is working hard to recruit physicians to our region, which often means offering top-quartile or even top-decile salaries to bring physicians from other parts of the country to relocate and serve the region's needs.

Additionally, Maryland is projected to have a shortage of over 1000 physicians *in primary care alone* by the year 2030[2]. This is exacerbated by the fact that one in three physicians in this state today are age 60 or older which will result in future shortages of physicians.

The rural parts of the state are hit the hardest with these trends. Primary care provider ("PCP") density is decreasing in over half of rural counties[3]. This is showing up in rural health outcomes where per capita ED visits are growing at nearly 12 times the growth rate of urban visits, according to one study published by The Journal of the American Medical Association (JAMA)[4]. This is not only a national problem, but one that impacts Maryland in the total cost of care in our non-urban parts of the state. The JAMA study also cites evidence that rural areas "face barriers to timely outpatient ambulatory and primary care services". The paper poignantly points out, "This finding is consistent with the documented intractable rural primary care shortage,[5] misdistribution of primary care favoring urban centers,[6] and rapid rural primary care physician turnover,[7]"

We feel strongly that accessible medical education focused on rural and suburban settings will attract a missing contingent of Maryland's future physicians to stay and learn right here in this state. Every year, some of the brightest young people in our state go to pursue a career as primary care physicians by studying at an out of state osteopathic medical school. These are young people with ties to our state and our rural communities who often end up establishing new roots and staying to practice in the state where they go to study. (For instance, 71% of students who go to train in California end up staying to practice in that state[8].)

By keeping these rural-focused physicians in Maryland, we will make major strides in addressing the access issues that are leading to the disparity in health outcomes in our rural areas. Please see **Feasibility Analysis page 5, Key Findings**: Physicians are needed in rural Maryland. Maryland has significantly fewer medical students and matriculants than other states and regions. Maryland needs to add at least 360 medical school matriculants to reach the national median matriculants per capita. Maryland is 18th in total US population but only 38th in medical school matriculants.

Maryland is extremely fortunate enough to have two of the world's most renowned medical schools located in our state. Johns Hopkins is widely regarded as the top institution in the world and attracts students from across the globe to train there. The University of Maryland Medical School is ranked consistently as one of the top ten institutions in the country. However, their uniqueness leads to a disproportionally small number of students staying to practice in state with a large percentage returning to their home state or country to pursue their careers.

By looking at residency match data, Meritus Health estimates that well under 30% of John Hopkins' graduates go on to residencies in a primary care related field while, across all specialties, less than 25% of graduates stay in-state for their residency. These results are to be expected at such elite institutions that attract students from across the globe. Since only 12%[9] of the school's matriculants have prior ties to the state, it is to be expected that the majority will go on to practice in other communities.

Based on this data that reflects a definitive need for physicians in Maryland and the uniqueness of the existing medical schools in our state, the Meritus Health leadership team feel the need for additional medical schools is clear and warranted at this time. The leadership team also believes that a focus on osteopathic medical education is the best way to maximize a benefit to the state and its residents.

More than half of all osteopathic medical school graduates go on to practice in primary care specialties[10], which is the area of greatest need throughout the country. Additionally, osteopathic medical schools tend to attract students with strong ties to the community where they are training. The American Association of Colleges of Osteopathic Medicine ("AACOM") finds that 44% of matriculants are "in state students"[11] and some schools figures are as high as 90%. This matches the leadership team's desire to develop an institution that attracts students from the region who intend to serve the state of Maryland and this community.

Additionally, the majority of medical schools are based in urban centers and the training is heavily reliant on rotations in high-acuity inpatient settings. The existing allopathic (M.D.) medical schools in Maryland (Johns Hopkins University's School of Medicine, the University of Maryland School of Medicine, and the Uniformed Services University F. Edward Hébert School of Medicine) are no exception with locations in Baltimore and Bethesda. Our intent, to create a medical school in a more rural part of the state, will give Maryland the opportunity to retain those students with a passion for addressing the underserved needs of these communities; students who would otherwise go on to train in the rural areas outside of the state.

(2) If some of the proposed programs serve societal needs (including the traditional liberal arts and non-occupational type programs) provide a description of how the proposed programs will enhance higher education in Maryland and contribute to the betterment of society in general.

MSOM's rural focus will capture the needs of the non-urban parts of the state in many ways. The community-based population health research will center on questions and

seek solutions to the obesity, diabetes, substance abuse rate. A two-month rural clerkship to address the marginalized populations in the Meritus Health Mobile Clinic will also be an important aspect of the curriculum. Our cases will include those chronic diseases that are so prevalent in populations with poor nutrition.

(b) If similar programs currently exist in the State, what are the similarities or differences in terms of the degrees to be awarded, the areas of specialization, and the specific academic content of these programs?

By combining the data from AACOM[12] and the Association of American Medical Colleges[13], the institution sees a compelling narrative that the state of Maryland is losing out to other states when it comes to growing the next generation of physicians.

- Maryland is 18th in population but 38th in medical school matriculants
- Despite similar populations, currently, Maryland only has 1 medical student as compared to Missouri, which has 4.4 students
- Although Wisconsin is a smaller state, they have 67% more medical students
- With under 2 million residents, neighboring West Virginia has 50% more matriculants in their 3 medical schools.
- Even with under 1 million residents, the neighboring city of DC has twice as many matriculants across their 3 schools.
- Across all states with medical schools and DC, Maryland is in last place in terms of matriculants per population
- To get to the national median matriculants per capita, Maryland needs to add at least 360 matriculants

Data suggests that the location of a physician's medical school has an impact on where that physician ends up practicing[14.] Given this assumption, the State of Maryland has historically been a net exporter of the best and brightest young people who are interested in medicine.

MSOM will be similar to other medical schools in the state in terms of providing students with a rich pre-clinical and clinical experience that will be delivered across four years. This will include similar simulated, experiential and apprentice modeled learning environments. However, MSOM will be the only medical school in the state to be situated in a rural region, to serve and train future physicians to provide care to these unique populations. The institution will emphasize community and population-based care that will be quite distinct and uniquely situated to meet and underserved need.

The data tells a compelling story on why more medical schools are needed in this state – especially osteopathic medical schools geared toward primary care in underserved communities. The institution is proud to meet this need through the proposed Meritus School of Osteopathic Medicine.

3. Financial Resources. The institution shall provide evidence of adequate financial resources to establish and maintain an institution of higher education in a form and manner prescribed by the Secretary. See COMAR 13B.02.02.06E(b)(c) & .07.

✓ **INSTRUCTIONS. Please enter the requested information in the spaces provided below, or create an attachment (labeled: "A-3 Financial Resources") to this application with your responses to the following questions:**

(a) Provide a long-range financial plan for the institution, which includes (1) a four year projection of anticipated income and expenditures that demonstrates that tuition and other sources of income shall be sufficient to provide a sound financial operation and assure diversity of intellectual interest and resources and (2) a preliminary budget for the school and its programs.

The Proposed Meritus School of Osteopathic Medicine (Applicant Status – Seeking Accreditation), ("institution" or "MSOM") will be a private, non-profit institution to be owned and operated by Hagerstown, Maryland-based Meritus Health and funded by the health system.

MSOM, by virtue of its parent organization, Meritus Health, has spent considerable time researching the necessary investment required of a school of osteopathic medicine. At the conclusion of that research and due diligence, the institution is confident that Meritus Health can provide the necessary financial resources and investment to support the institution during its infancy until MSOM's independent financial stability, which is expected in 2028.

In September 2021, Fitch Ratings upgraded the rating on the series 2015 revenue bonds issued by the Maryland Health & Higher Educational Facilities Authority of Maryland on behalf of Meritus Medical Center (Meritus) to 'A' from 'A-' and additionally, Fitch also upgraded Meritus' Issuer Default Rating to 'A' from 'A-'.

Included in the report was the following Analytical Conclusion that demonstrates the strength of MMC, and you may view the report here as **Exhibit – FitchRatings Report**.

The upgrade to 'A' reflects the Meritus Health system's very strong operating cash flow in fiscal 2021 (ending June 30) and investment portfolio performance that has resulted in a material year-over-year improvement in Meritus' leverage metrics. With Meritus Health uniquely positioned as the only provider in Washington County, the rating also reflects a robust market share in a state with predictable revenue streams under the Global Budget Revenue ("GBR") reimbursement methodology.

With this Fitch rating report in mind, we present the following high-level projection of revenues and expenses that include, but are not limited to the following expectations:

The Proposed MSOM, like most osteopathic medical schools, will be tuition supported and MSOM will have sufficient class sizes and market-based tuition that will enable it to operate at a break-even in year three (3) of academic operations and at a surplus beginning in its fourth year of operations with students. In year 6, we expect our

ongoing operating margin to stabilize near 22%. Please see the included table here as **Exhibit – Start Up Summary** that provides a summary of the start-up through break-even for the proposed SOM.

Given the approximate 5-year period to invest in the infrastructure and leadership plus accreditation and licensing approvals, the proposed MSOM is projecting that it will need $103 million of capital to support this initiative. The Sources and Uses table illustrate the estimated funding for this project including the funding to be provided to bridge the required working capital until the proposed MSOM reaches break-even operations and is sustainable going forward.

The included table details the working capital of approximately $53 million will be needed to support operations through the first 3 years of operations. Operating losses will be supported from funding from Meritus Medical Center ("MMC"). MMC has $375 million of cash and unrestricted investment income as of June 30, 2022. MMC's board has pledged support for this project. Please see **Exhibit – Sources and Uses** to view the table.

In the initial application phase of the project, 100% of the operational funding is being provided by MMC. The initial applicant stage, July 2022 through June 2025, is projected to need financial support of $22M.

To help support MSOM's operation and garner greater community support, a fundraising campaign will officially kick off in January 2023. A soft launch of our fundraising campaign has already begun, and the foundation has raised over $1 million for both the construction of the medical school and ongoing operational support.

Funding from the community is expected to be over $5 million through individual donors, companies, and other entities. However, the success of this venture is not reliant on donations. MSOM has also received funding commitments from a broad collection of organizations and community groups interested in supporting the new Proposed School of Osteopathic Medicine.

Escrows: MSOM has the commitment from the MMC management and the board to provide the necessary financial support to ensure the success of MSOM. As of June 30, 2022, MMC has over $250 million of unrestricted investments that will be utilized for the required $50M of escrow funds. MMC recognizes the escrow will be restricted and unavailable for other uses until after the first graduating class in 2029. The escrow will continue to be invested during that period in a security acceptable under the escrow agreement to ensure the required balance is always readily available.

Building, Equipment and Technology: The capital plan for the institution is approximately $73 million in property, plant, and equipment (PP&E), which will include the 190,000 SF building, and approximately $10 million in labs, technology, simulation technology and equipment that will showcase the commitment to excellence that Meritus Health is ensuring to establish to demonstrate to MHEC that this project has the unequivocal backing of Meritus Health.

The building will be constructed on a parcel of land adjacent-to and owned by MMC. The construction of the medical school will be built at the expense of MMC and leased to MSOM upon occupancy. If unforeseen circumstances lead to a delay in the completion of the medical school academic building, MSOM has two options for temporary classroom locations. The first option is a partnership with Hagerstown Community College to temporarily use space on their campus, less than 1 mile from MMC. The second option would be to offer coursework on the MMC campus that would include two conference room spaces that total approximately 9,700 SF.

Working Capital: The table below illustrates the Preliminary Budget for MSOM.

PRELIMINARY BUDGET ($000s)

Operating Year (FYE 6/30)	**FY 2026**	**FY 2027**	**FY 2028**	**FY 2029**
Student Enrollment:				
First-Year	90	135	180	180
Second-Year		90	135	180
Third-Year			90	135
Fourth-Year				90
Total Enrollment	**90**	**225**	**405**	**585**
Operating Revenues:				
Student Tuition				
First-Year	$4,950	$7,425	$9,900	$9,900
Second-Year		4,950	7,425	9,900
Third-Year			4,950	7,425
Fourth-Year				4,950
Student Fees				
First-Year	450	675	900	900
Second-Year		450	675	900
Third-Year			450	675
Fourth-Year				450
Investment & Interest Income	1,061	1,082	1,104	1,104
Application Fees	200	200	300	300
Total Revenues:	**$6,661**	**$14,782**	**$25,704**	**$36,504**
Operating Expenses:				
Personnel Expenses				
Salaries	9,361	11,005	11,225	11,449
Benefits	2,621	3,081	3,134	3,206
Admin/Lab Support	357	364	371	371

Total Personnel Expenses	12,340	14,1450	14,739	15,027
Other Operating Expenses	5,181	6,400	10,900	13,000
Total Operating Expenses:	**$17,520**	**$20,850**	**$25,639**	**$28,027**
Operating Surplus (Deficit):	**$(10,859)**	**$(6,068)**	**$65**	**$8,477**

Since the only program offered will be the DO degree program, the institution is anticipating a maximum approved class size of 180 students per cohort. Enrollment for the first two (2) years, however, will be at 50% and 75%, respectively of approved class sizes due to the standards of the accrediting agency. By year five (5) of operations, the MSOM enrollment in its DO program is expected to grow from 90 in the initial cohort to be approximately 675 students.

Management is anticipating having profitable operations on a sustained basis beginning with the fourth class of students. Medical schools generally have one (1) intake of students per year and therefore will have only a fraction of the future revenue from the first class of 90 students in year one (1) and will steadily build in years two (2), three (3) and four (4) when MSOM will be generating tuition revenue for four (4) classes of students. The financial plan and anticipated investment / donation / bond / debt funding available will be sufficient to absorb these expenses and costs associated during the ramp up period.

According to AACOMAS (in 2021 for applicants at DO programs in the US) a total of 27,277 students applied and 8,516 matriculated leaving 18,761 applicants remaining. The projected demand for available seats in medical school is expected to continue. Please see **Feasibility Analysis page 56**.

Given the demand dynamic addressed above, MSOM expects qualified applicants in excess of the anticipated maximum approved class sizes of 180. MSOM's enrollment strategy is to evaluate the anticipated 2000 applications to select students that align with the stated mission and purpose of the institution and possess the undergraduate preparation, MCAT test scores and background to become qualified physicians serving underserved rural populations in the Maryland and surrounding regions.

The proposed MSOM will continue to update the financial pro forma as the facility plans and the financial impact from other aspects of the medical school undergo development and are summarized initially as follows.

(b) If available, provide a certified copy of the institution or its parent institution's **most recent audited financial statement**. (Copy attached? ☒ Yes ☐ No)

The institution is including as a part of this application, the parent organization, Meritus Health's most recent audited financial statements for the years 2019, 2020 and 2021. Please see each year by clicking on the following links:

Exhibit – Meritus Health Audited Financial Statements - 2019
Exhibit – Meritus Health Audited Financial Statements - 2020
Exhibit – Meritus Health Audited Financial Statements - 2021

(c) List the name of the chief financial officer of the institution, giving (1) the preparation by education (institutions and degrees) and experience for his/her work and (2) his/her involvement with the operation of the institution's educational facilities and programs.

Mr. Josh Repac, CPA, who currently serves as the Chief Financial Officer and Vice President for Meritus Health, revenue cycle and clinical support services, previously served as the Executive Director of revenue cycle and reimbursement for Meritus Health. Prior to coming to Meritus Health, Mr. Repac served as Director of the Berkeley Research Group and Manager Advisory of KPMG, LLP, both health care reimbursement companies located in the Baltimore region.

Mr. Repac is a Certified Public Accountant and holds a master's degree in Business Administration from the University of Baltimore/Towson University and a Bachelor of Science in accounting from the Robert H. Smith School of Business at the University of Maryland, College Park.

Mr. Repac is the Founding CFO for the proposed Meritus School of Osteopathic Medicine (Applicant Status – Seeking Accreditation). Mr. Repac has been with the Meritus Health organization in one capacity or another since 2018. His wealth of knowledge combined with his business and academic experience will provide the necessary expertise to ensure that the institution will carry on the strong traditions and values of the Meritus Health system.

Mr. Repac's CV and copy of Degree diploma from his highest degree obtained are included as exhibits to this submission to support his qualifications for the position.

Please see the following Exhibits:

Exhibit – Josh Repac – CV
Exhibit – Josh Repac – Diplomas
Exhibit – Josh Repac – CPA License

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Please Submit All Information To:

Maryland Higher Education Commission
Office of Academic Affairs
6 N. Liberty Street, 10th Floor
Baltimore, Maryland 21201
(410) 767-3300
acadprop.mhec.@maryland.gov (for electronic submissions)

Meritus Health
11116 Medical Campus Road
Hagerstown, MD 21742
Phone 301-790-8000

EXHIBITS FOLLOW THIS PAGE

Meritus Health

MERITUS MEDICAL CENTER, INC.
11116 Medical Campus Road, Hagerstown, MD 21742

Bank of America
100 NORTH TRYON STREET
CHARLOTTE, NC 28255

902226

7-163/520MD

902226

0006689

Date 08/19/22

Amount ****$7500.00

Pay SEVEN THOUSAND FIVE HUNDRED 00/100

VOID AFTER 180 DAYS

To the Order of
MARYLAND HIGER EDUCATION COMMISSION
6 N. LIBERTY STREET, 10TH FLOOR
BALTIMORE, MD 21201

Maulik Joshi MP
AUTHORIZED SIGNATURE

Security features included. Details on back.

⑈902226⑈ ⑆052001633⑆ 4460266148⑈

MERITUS MEDICAL CENTER, INC. 902226

902226
Date 08/19/22

Invoice	Date	Description	Gross	Discount	Net
MHEC 8/19/22	08/19/22		7500.00	0.00	7500.00
		Totals ▶	7500.00	0.00	7500.00

0006689

MERITUS MEDICAL CENTER, INC. 902226

MARYLAND HIGER EDUCATION COMMISSION

902226
Date 08/19/22

Invoice	Date	Description	Gross	Discount	Net
MHEC 8/19/22	08/19/22		7500.00	0.00	7500.00
		Totals ▶	7500.00	0.00	7500.00

0006689

Feasibility Analysis

for the Development of an Osteopathic Medical School at Meritus Health (MSOM)

September 2022

Tripp Umbach

trippumbach.com

MERITUS SCHOOL OF OSTEOPATHIC MEDICINE

Meritus

MARYLAND

Table of Contents

Executive Summary

Introduction

Meritus Health retained Tripp Umbach to assess the feasibility of the proposed Meritus School of Osteopathic Medicine (MSOM) to analyze and independently assess the possibility of an osteopathic medical school in Hagerstown, Maryland.[1] Tripp Umbach completed a comprehensive process involving secondary data analysis, a financial model review, and economic impact projections. This report aims to evaluate the feasibility of developing a medical school that produces physician leaders who understand the complexities of practicing primary care medicine in rural areas. The vision for the MSOM is to improve population health through a focus on interprofessional education,[2] advanced technology and data, clinical experience in rural settings, and care models addressing social determinants of health (SDOH).[3]

The findings contained herein represent the professional opinions of Tripp Umbach based on assumptions and conditions detailed in this report. Tripp Umbach collected and analyzed primary and secondary data to assess the need and feasibility of developing a medical school in Hagerstown. The feasibility report plays an integral role in furthering the ongoing planning efforts required if the proposed medical school applies for accreditation and requests approval from the American Osteopathic Association's Commission on Osteopathic College Accreditation (COCA). Specifically, this report allows the MSOM leadership team to understand the overall health care needs of the state of Maryland and the surrounding states of Pennsylvania and West Virginia, as well as the benefits associated with the development of a campus to serve the multistate region.

The state of Maryland has significant needs for physicians in both rural and underserved urban areas. To address these growing needs, Maryland must grow its physician workforce to better address the healthcare needs of its people. Tripp Umbach believes that physician shortages in Maryland can best be addressed by developing two independent osteopathic medical schools. Therefore, the proposed Meritus School of Osteopathic Medicine (MSOM) and Maryland College of Osteopathic Medicine (MDCOM) at Morgan State University will be complementary and not competitive as they move forward within the same timeframe. The MSOM will be focused on rural and underserved areas in Western Maryland and other rural areas of Maryland, and the MDCOM will focus on underserved urban and diverse populations. The MSOM will provide a first-rate rural training track to produce physicians who will practice in Western Maryland and other rural areas of Maryland.

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[1] Tripp Umbach is the nation's most experienced consulting firm in academic medicine, serving national associations, 100 existing medical schools, more than 800 hospital systems, and 500 universities since 1990. Over the past 20 years, Tripp Umbach has been involved in most medical school development and expansion projects in the United States, completing more than 50 similar studies that have led to 30 new medical schools.

[2] Interprofessional education (IPE) occurs when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes.

[3] Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

The report sets forth Tripp Umbach's findings for the feasibility of an osteopathic medical school in Hagerstown (referred to throughout the report as the proposed MSOM).

Key Findings

Tripp Umbach's analysis supports the following key findings for the proposed Meritus Health School of Osteopathic Medicine. (Below are the key findings, in no particular order.)

1. Physicians are needed in rural Maryland due to the increased population and an aging physician workforce.

The pandemic exposed significant disparities in accessing health care and highlighted physicians' important role in the nation's health care infrastructure. The primary driver of increased physician growth is the growing and aging population. From 2019 – 2034, the U.S. population is projected to grow by 10.6%, from about 328 million to 363 million, with a 42.4% increase in those aged 65 and above. Thus, the demand for physicians that predominantly care for older Americans will continue to increase.[4]

The American Association of Medical Colleges (AAMC) projects a shortage of surgical specialties (e.g., general surgery, obstetrics and gynecology, orthopedic surgery) between 15,800 – 30,200, medical specialties (e.g., cardiology, oncology, infectious diseases, pulmonology) between 3,800 and 13,400, and other specialties (e.g., anesthesiology, neurology, emergency medicine, addiction medicine) between 10,300 and 35,600 physicians.[5] In the U.S., primary care physicians (PCPs) currently represent less than one-third of the total physician workforce. Solutions to strengthen the number of practicing physicians in rural and urban settings have been top of mind for many states for decades.[6]

Medical specialty shortages are emerging, which will pose a serious challenge to public health. Factors driving physician supply and demand include an aging population, aging physician supply, static supply of physicians, and chronic illnesses. The need for specialists will grow as the aging population becomes sicker and older. Physicians with the degree of Doctor of Osteopathic Medicine (D.O) provide distinctive and valuable contributions to the practice of medicine in all specialties. Across the nation, more than 117,000 D.O.s in active practice treat patients in a wide variety of specialties and practice settings. Over the past decade, the number of D.O.s choosing non-primary care specialties has steadily increased. More than one-third (43.5%) practice in other sub-specialties.[7]

According to the Health Resources and Services Administration (HRSA) Health Workforce, the need for more primary-care physicians is substantial. As of September 2021, there are 7,447 Primary Care Health Professional Shortage Areas (HPSAs) throughout the United States, with 83.7 million people living within these areas. Maryland has 48 primary-care HPSA designations, totaling a population of 887 thousand within the HPSAs. Therefore, the state would need 141 additional primary care physicians to remove this designation.[8]

[4] American Association of Medical Colleges
[5] American Association of Medical Colleges
[6] The Robert Graham Center
[7] American Osteopathic Association
[8] Kaiser Family Foundation

The Robert Graham Center forecasts that by 2030, Maryland will need an additional 1,052 primary-care physicians (PCPs), a 23% increase compared to the state's 2010 primary-care physician workforce. Components of Maryland's increased need for PCPs include 28% (303 PCPs) from increased utilization due to aging, 61% (651 PCPs) due to population growth, and 9% (98 PCPs) due to a greater insured population following the Affordable Care Act (ACA).[9] Pressures from a growing, aging, increasingly insured population call on Maryland to address the current and growing demand for PCPs to meet health care needs adequately. The Robert Graham Center recommends bolstering the primary care pipeline by imploring physician reimbursement reform, dedicating funding for primary care graduate medical education (GME), increasing primary care funding training, and increasing medical school student debt relief.[10]

As of 2018, slightly more than one-third of Maryland physicians are 60 years or older (34.1%), adding to the aging physician workforce. Maryland has the eleventh highest rate in the country of active physicians aged 60 or older. Their retirement within the next few years will leave a significant hole in the state's physician workforce and further impact its ability to seek care.[11] For a state already experiencing physician shortages, an aging physician workforce will pose a greater issue as the number of physicians retiring will increase the need. Undoubtedly, there will be a significant workforce shortage, and the most effective solution will be to train more physicians.

2. Physicians are needed in rural Maryland.

People living in rural communities throughout Maryland face difficulties obtaining and securing health care services. Of the more than 7,200 federally designated health professional shortage areas, 3 out of 5 are in rural regions. And while 20% of the U.S. population lives in rural communities, only 11% of physicians practice in such areas.[12]

Across the country and in communities in rural Maryland, the need for physicians grows. Physician shortages loom in both rural Eastern and Northwestern Maryland. Residents in rural underserved communities face more disparities due to access to primary care services, contributing to other poor health outcomes such as cardiovascular diseases, unintentional injury, and late-stage cancers. Many residents are forced to travel out of state for medical care.

Maryland has significantly fewer medical students and matriculants than other states and regions. Maryland needs to add at least 360 medical school matriculants to reach the national median matriculants per capita. Maryland is 18th in total US population but only 38th in medical school matriculants. While Maryland and Missouri have similar populations, there is only one Maryland medical student to every 4.4 in Missouri. Although Wisconsin is a smaller state, there are 67% more medical students in Wisconsin. Even West Virginia with under 2 million residents, has 50% more matriculants in its three medical schools.

[9] The Robert Graham Center
[10] The Robert Graham Center
[11] Association of American Medical Colleges
[12] Association of American Medical Colleges

In Maryland, there are only four family medicine residency training programs. Nationally, the number of family physicians graduating from the Accreditation Council for Graduate Medical Education-accredited programs declined from 3,225 in 2005 to 2,970 in 2012, then increased to 3,383 by 2017. Between 2011 and 2017, the state produced a total of 119 family physicians; of these, 49 (41%) stayed in-state. The loss of state-trained family physicians is offset by the in-migration of 146 family physicians trained in other states.[13] Maryland can increase the PCP pipeline through elevated efforts, partnerships with state medical schools, and support of family medicine residency programs statewide. More than half of the nation's D.O. s practice in primary care specialties such as family medicine, internal medicine, and pediatrics (57%), while the remainder provides care in emergency medicine, obstetrics & gynecology, surgery, etc.[14]

3. Osteopathic medicine is the fastest-growing health care profession.

The osteopathic medicine field has a strong heritage of producing primary care practitioners. Fundamentally, the mission statements of many osteopathic medical schools cite the production of primary care physicians. The osteopathic medicine tradition preaches that a strong foundation in primary care makes one a better physician, regardless of what specialty one may eventually practice. Osteopathic medicine provides hands-on diagnosis and treatment, emphasizing treatment that helps people achieve a high level of wellness by focusing on health promotion and disease prevention.[15]

The osteopathic medical profession has a long tradition of providing care where patients lack doctors. In 2021, the number of osteopathic physicians in the United States climbed to nearly 135,000, an 80% increase over the past decade. There are currently 168,701 Doctor of Osteopathic Medicine (D.O.) and osteopathic medical students in the United States, with 134,901 being D.O.s. In the U.S., thirty-seven accredited osteopathic medical colleges teach at 58 locations.[16]

In 2021, 67% of all D.O.s were age 45 or younger. The diversity of students continues to increase – in 2019-20, 10.7% of first-year enrollees were minorities compared to in 2010-11 at 7.2%. The number of female D.O.s also continues to trend each year upward. While roughly 43% of D.O.s are women, female physicians comprise 74% of the D.O. population under age 45.[17]

Annually, the number of D.O.s in medical practice continues to grow; however, this is in conjunction with the nation's growing physician shortage. D.O.s are ideal for taking on a larger role in supplying much-needed physicians nationally, particularly in disenfranchised communities. The profession's strong primary care base also addresses physician shortages in medically underserved regions. In fact, six of the 10 U.S. medical schools that produce the most primary-care residents are osteopathic medical schools, according to U.S. News & World Report's annual ranking of medical schools for 2021.[18]

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[13] The Robert Graham Center
[14] American Osteopathic Association: Osteopathic Medical Profession Report
[15] American Association of Colleges of Osteopathic Medicine
[16] American Osteopathic Association; 2020-21 AOA: Osteopathic Medical Education Report
[17] AACOM, Annual Osteopathic Medical School Questionnaires, 1976-1977 through 2019-20 academic years.
[18] American Osteopathic Association

4. The proposed Meritus School of Osteopathic Medicine in Hagerstown, Maryland, will significantly drive the regional economy.

The proposed osteopathic medical school in Hagerstown will bring a new revenue stream to the state and will most likely inspire additional economic development through the expansion of other health science education programs, clinical and research partnerships with nearby community hospitals, and private business expansions that may be developed. Construction alone during the three years related to the development of the medical school will generate $268.0 million in revenue for the local economy, support 1,595 jobs, and generate $6.2 million in taxes.

When the proposed school welcomes its first class in 2025, it will have an economic impact (direct and indirect economic benefits) of $46.0 million, more than 288 jobs, and $1.4 million in taxes to communities in the region. In addition to the operational impact outlined above, by 2029, the economic impact of the proposed campus will grow to $120.0 million as Hagerstown communities will begin realizing health care benefits and additional economic impact as graduates of the campus located in the region and state. Tripp Umbach estimates that by 2032 when the first class of medical students completes their residencies, these new primary care physicians will also yield actual savings, as emergency room utilization declines, for example. These savings are expected to total $142.6 million annually by 2032. By 2032, the total economic impact of the proposed college on the Hagerstown region will equal more than $128.4 million, support over 626 jobs, and contribute more than $5.0 million to state and local governments.

The proposed Meritus College of Osteopathic Medicine in Hagerstown Maryland can transform and drive the regional economy over the next 20 years, provided its mission and vision are in place from its inception. The MSOM will create a strong economic and employment impact on the region while raising the quality of health care delivery. A broad vision for health improvement and economic development in a region expected to attract and increase population growth will require the proposed osteopathic medical school to be positioned for such growth from the start.

5. The proposed Meritus Health SOM will be financially viable.

Positive cash flow and margins when the college graduates its first class provide a strong measure of sustainability. MSOM has a favorable pro forma demonstrating this project's financial viability. The projected annual revenue for this project at the time the first cohort of student graduates is $37.5 million.

6. Strong community support for developing an Osteopathic Medical School at Meritus Health.

Community stakeholders interviewed by Tripp Umbach unanimously believe Meritus Health is distinctively positioned to develop a high quality osteopathic medical school to produce physicians who will practice in rural Maryland. The proposed Meritus School of Osteopathic Medicine would seek the

strengths of its partnerships with regional educational systems and other health care facilities to train physicians to address the growing health care needs of rural and underserved Marylanders.

Building upon Meritus Health's existing health care framework appealed to community stakeholders. According to stakeholders, developing an osteopathic medical school is in the region's best interest. The overall benefits range from improved population health of rural residents to a strong economic community infrastructure to improving other business sectors. Community stakeholders all agreed that Meritus Health has a strong entrepreneurial culture required to develop and sustain a successful medical school and produce high-caliber physicians in collaboration with other Maryland medical schools, higher education institutions, and community health organizations.

As a health care leader in western Maryland, Meritus Health brings experienced faculty and high-quality health care services to residents in Maryland, West Virginia, and Pennsylvania. Meritus Health's multiple medical practices and numerous providers will engage students in multi-interdisciplinary education. In addition, community stakeholders believe that Meritus Health has the vast experience and reputation required to develop and lead a new osteopathic medical school in collaboration with community health organizations to improve, maintain, and address the needs of rural Maryland.

Tripp Umbach Recommendation

The proposed Meritus School of Osteopathic Medicines should move forward at Meritus Health in Hagerstown, Maryland.

Tripp Umbach recommends that the MCOM move forward with applicant status with the Commission on Osteopathic College Accreditation (COCA) to develop a four-year osteopathic medical school at Meritus Health in Hagerstown, Maryland. Tripp Umbach recommends a starting class size of 90 students, growing to 180 at full maturity. Tripp Umbach recommends that as the MSOM moves forward with developing a proposed osteopathic school of medicine, a business plan submitted by the Founding Dean to COCA should include formal affiliation letters from a wide range of clinical partners in addition to Meritus Health.

Key Factors for Success

The Commission on Osteopathic College Accreditation has multiple standards that must be met and maintained. The success of the new osteopathic medical school will be based upon having the following in place:

- Clear mission and areas of focus that distinguish the new osteopathic medical school at the MCOM in curriculum, research, and community service.
- Deeply rooted clinical education partnerships with Meritus Health and other clinical partners.
- Facilities and technology that support student achievement.
- Integrated Graduate Medical Education (GME) programs within Meritus Health.
- Ongoing demonstration of economic impact and return on investment.

- Ongoing development of community health improvement programs.
- The development of appropriate facilities to deliver the medical education program.
- The recruitment of an experienced and effective Founding Dean.
- The recruitment of high-quality faculty and students.

The Proposed Meritus School of Osteopathic Medicine (MSOM)

The Future of the Health Care System

An increasingly complex health care system has led to transformations in service delivery during the past decade. These transformations emphasize:

- Generalist and primary care.
- Managed care that links inpatient and outpatient services.
- Continuity of health care services in partnership with communities.
- Cost-effective care and population approaches.
- Accountability for outcomes.
- An explosion of information technologies.

Although it is hard to distinguish between public health and personal health care, the near collapse of health care reform and the blurring of lines between individual and population-based health are forcing practitioners to understand and negotiate both worlds. Such trends reinforce the need to improve education and training in interdisciplinary collaboration for personal care and health initiatives aimed at communities and population groups.[19]

The terms "population" or "population-based" care increasingly coupled with "health," "healthcare," "medicine," "medical care," or "managed care" indicate a changing reality in the organization and delivery of health care in the United States.

According to the AAMC: "A population health perspective encompasses the ability to assess the health needs of a specific population; implement and evaluate interventions to improve the health of that population; and provide care for individual patients in the context of the culture, health status, and health needs of the populations of which that patient is a member."[20]

Overview

Rural Americans' dependency on health care services depends upon an ample supply of rural physicians. Continued efforts to address the physician shortages in rural areas have not been successful. A balanced action among those involved in medical education is needed to promote the rural practice. Despite massive contributions family physicians have provided to rural residents, rural areas have been medically underserved for decades. In the US there are currently 494,821 active primary care physicians,

[19] Interdisciplinary is an approach characterized by a high degree of collaboration and communication among health professionals. What makes integrated health care unique is the sharing of information among team members related to patient care and the establishment of a comprehensive treatment plan to address the biological, psychological, and social needs of the patient. The interdisciplinary health care team includes a diverse group of members (e.g., physicians, psychologists, social workers, and occupational and physical therapists), depending on the needs of the patient.

[20] Association of American Medical College

and there is not an adequate distribution of these to meet the needs of the 20% of Americans that live in rural areas.[21]

Evaluation of Medical Education and Rural Physician Workforce Needs

Americans living in rural parts of the state do so for multiple reasons. Fewer people, more affordable living, a stronger sense of community, and a calmer lifestyle. Unfortunately, nearly 1 in 5 people live in rural areas in the U.S. Rural residents tend to be older and are at higher risk for poor health outcomes than urban residents. Rural Americans face significant health challenges.

"Compared to urban residents, people living in rural areas are more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke."

U.S. Food & Drug

Rural Americans face a greater risk of death from heart disease, cancer, unintentional injuries, chronic lower respiratory diseases (CLRD), and stroke when compared to urban Americans. Deaths among rural Americans are potentially preventable, including 25,000 from heart disease, 19,000 from cancer, 12,000 from unintentional injuries, and 11,000 from CLRD. [22] Again, many avoidable deaths are higher in rural areas compared to urban locations. In addition, socioeconomic factors have also placed rural residents at higher risk factors.

Living in a rural community, resources and services are limited, affecting ways to maintain and engage in a healthy lifestyle. A rural resident's geography limits access to many resources such as health care, employment, education, food, housing, etc., which impact health. Rural communities have higher poverty rates, employment, and low education. Accessing grocery stores that carry healthy fresh foods and the unavailability of fitness centers are challenges in rural living.

Rural Americans face significant health disparities due to physician shortages and the inability to access care. Rural Americans cannot obtain health care services simply due to the low numbers of providers. Traveling great distances for appointments and specialty care services is not unusual. Rural residents are typically diagnosed with late-stage cancer as many do not have access to clinical trials or state-of-the-art equipment, and many are unwilling to travel significant distances for preventive care services and screenings. The National Rural Health Association reports a ratio of patients to primary care physicians in rural areas at 39.8 per 100,000, compared to 53.3 per 100,000 in urban areas. Family physicians, who make up only 15% of the physician workforce nationwide, provide 42% of the care in rural areas.[23]

The New England Journal of Medicine forecasts that retirement will account for 23% of rural doctors by 2030. Fewer physicians will practice in rural America, exacerbating access to care services.[24]

[21] Kaiser Family Foundation
[22] Centers for Disease Control and Prevention
[23] National Rural Health Association
[24] The New England Journal of Medicine

Rural Physicians

Rural health can be defined as the health of people living in rural areas, generally located farther from health care facilities and other services than those living in urban areas. Rural residents tend to be older adults, disabled, and veterans living in rural areas. Rural areas tend to have higher rates of people without health insurance and limited access to health care services because many medical centers in rural areas are closing.

Maryland has 18 rural counties out of 24 counties, with twenty-five percent of the population living in these counties. These rural communities include Allegany, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Kent, Queen Anne's, Somerset, St. Mary's, Talbot, Washington, Wicomico, and Worcester. Much like other rural counties in the U.S., residents in rural Maryland face health care concerns, including a lack of health care providers and difficulty accessing those providers due to transportation and technology barriers.

Rural hospitals and health care providers are shrinking. In fact, since January 2005, 182 rural hospitals have closed, creating additional gaps in care for rural residents.[25] Rural residents face higher rates of death from chronic diseases and unintentional injuries. They are also more likely to have multiple health conditions such as heart disease, stroke, hypertension, diabetes, and arthritis. Members of racial/ethnic minority, tribal, and other diverse groups in rural areas are at higher risk for poor health outcomes. American Indian/Alaska Native, African American, and Hispanic/Latino adults living in rural areas reported higher rates of fair or poor health than non-Hispanic white adults. Rural African American and American Indian/Alaska Native adults are more likely to have multiple chronic health conditions than non-Hispanic white adults.[26]

It should be noted that several factors make a physician more likely to choose rural practice over urban. Family physicians and those with rural backgrounds are more likely to locate and practice in rural areas than those with urban backgrounds. Medical schools that aim to train rural physicians are also more likely to produce rural physicians. An additional factor is that the osteopathic philosophy predicts why 60% of new osteopathic medicine graduates choose primary care, compared with 24% of their M.D. counterparts who seek high-paying specialties such as surgery and cardiology.[27] Rural rotations and other rural curriculum requirements in medical school and residency training are critical to maintaining students who have an interest in rural practice from practicing elsewhere.

Research suggests that physicians who were better medically and socially prepared for practice in a rural area stayed longer than those who felt unprepared. Physicians who are prepared to be rural physicians, particularly those prepared for small-town living, stay longer in their rural practices. Residency rotations in rural areas are the best educational experiences both to prepare physicians for rural practice and to lengthen the time they stay there.[28]

[25] University of North Carolina: the Cecil G. Sheps Center for Health Services Research
[26] U.S. Food and Drug Administration
[27] Kaiser Health News
[28] National Institutes of Health; National Library of Medicine

The table below shows the number of physicians per 10,000 per population for metropolitan and nonmetropolitan counties in Maryland. The information includes the total number of physicians, Doctor of Medicine (M.D.s), doctors of osteopathy (D.O.s), and primary care physicians.

The data reveals that D.O.s are more likely to practice in nonmetropolitan counties when compared to metropolitan counties and their MD counterparts. In 2021, the number of D.O.s practicing in Maryland was 1,404 or 1.0%.[29]

Table 1: Physicians per 10,000 People for Metro and Nonmetro Counties, 2019 – Maryland

	Metropolitan	Nonmetropolitan
M.D. s	41.758	18.289
D.O. s	1.323	2.062
Primary Care Physicians	9.005	6.119
Total Physicians	**43.081**	**20.351**

Source: Rural Health Information Hub

Rural Health

As defined by the World Health Organization (WHO),[30] SDOH are the economic and social conditions that influence an individual in health status. These economic and social conditions increase or decrease the risk for health conditions or disease among individuals and populations. Addressing SDOH is paramount to creating a healthy community as they contribute to health disparities and inequities across the nation.

Educational attainment, low-income levels, race/ethnicity, and health literacy all impact the ability of people to access health services and to meet their basic needs, such as safe housing, transportation, and food security which are essential to staying healthy. Rural residents are more likely to experience contributing social factors that impact health, such as poverty. On average rural Americas face more inequities when compared to the nation overall. Rural residents tend to be less educated and poorer and cannot access community resources, including health services. The impact of these obstacles further intensifies the barriers already present due to their geographies, such as limited public transportation and limited options for healthy foods.

[29] American Osteopathic Association; Osteopathic Medical Professional Report
[30] World Health Organization

Table 2: National Rural Health Snapshot

National Rural Snapshot	Rural	Urban
Percentage of population	19.3%	80.7%
Number of physicians per 10,000 people	13.1	31.2
Number of specialists per 100,000 people	30	263
Population aged 65 and older	18%	12%
Average per capita income	$45,482	$53,657
Non-Hispanic white population	69-82%	45%
Adults who describe health status as fair/poor	19.5%	15.6%
Adolescents who smoke	11%	5%
Percentage of dual-eligible Medicare beneficiaries	30%	70%
Medicare beneficiaries without drug coverage	43%	27%
The percentage covered by Medicaid	16%	13%

Source: Rural Health Information Hub

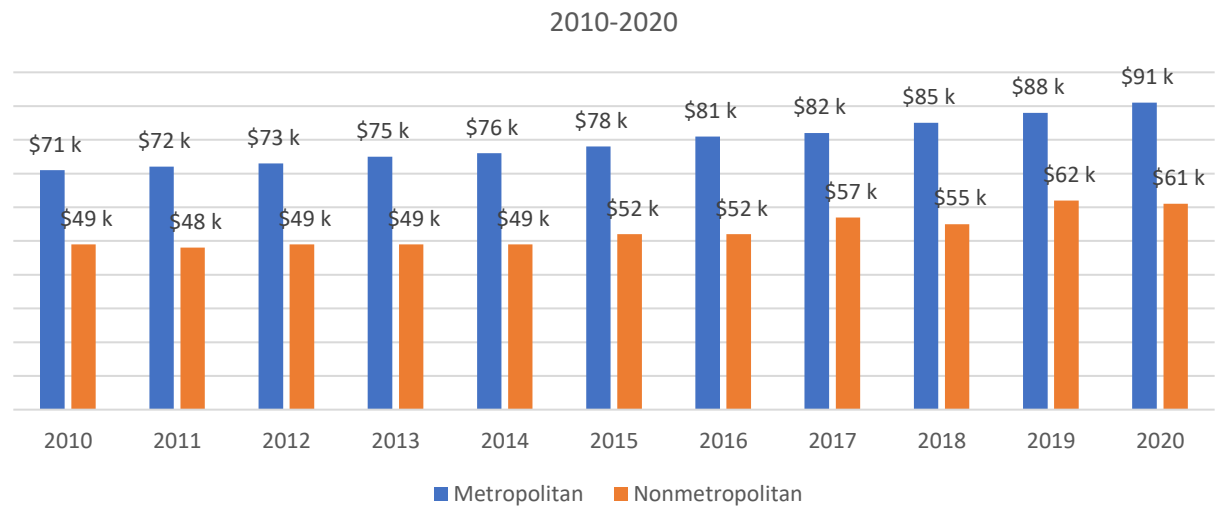
Rural Americans tend to engage in poor health behaviors and have worse outcomes such as high blood pressure, smoking, lack of exercise, and obesity when compared to residents in urban areas. Rural residents have higher poverty rates, are less likely to have health insurance, and have less access to health care.

The data in the following figures reveal the health disparities between metropolitan and nonmetropolitan regions. Nonmetropolitan areas in Maryland are more likely to report higher deaths from cancer, chronic lower respiratory disease (CLRD), heart disease, and stroke. Data also uncovers higher percentages of residents with diabetes, unintentional injuries, and obesity.

The figure below depicts the average median household income for metropolitan and nonmetropolitan counties in Maryland from 2010 through 2020.[31]

[31] Rural Health Information Hub

Figure 3: Average Median Household Income for Metro and Nonmetro Counties — Maryland

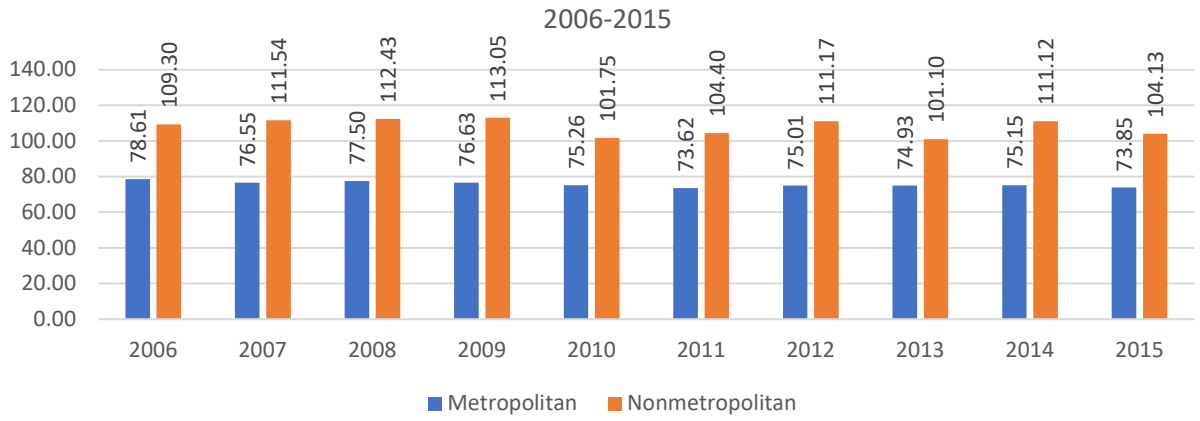


(Note: Date for Figures --- were obtained from the Rural Health Information Hub unless otherwise noted.)

Source: Rural Health Information Hub

The figure below shows metropolitan and nonmetropolitan deaths due to cancer from 2006 through 2015 per 100,000 population.

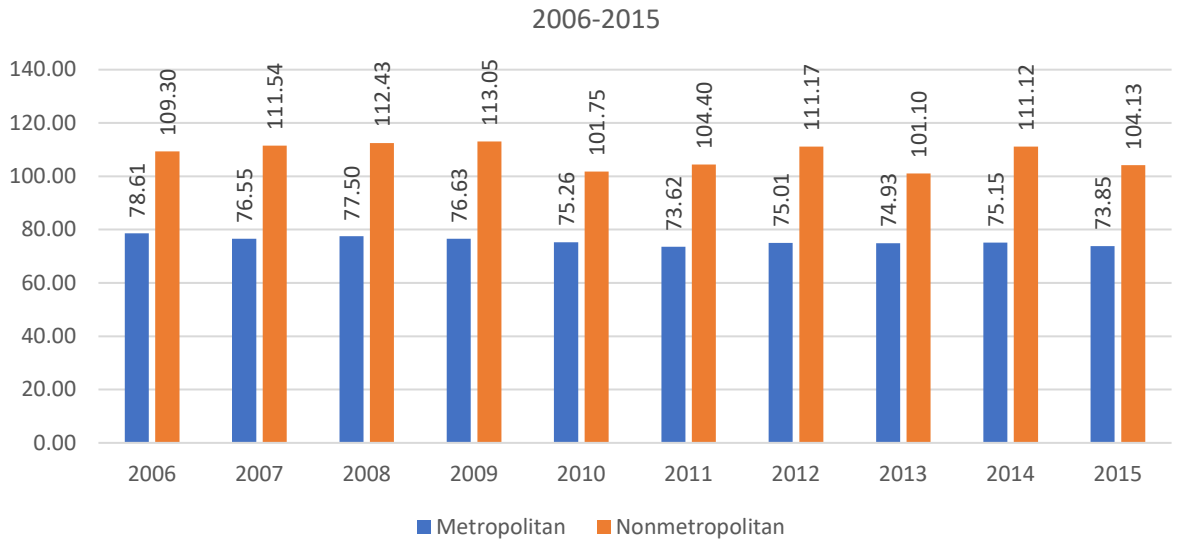
Figure 4: Deaths from Cancer for Metro and Nonmetro Counties — Maryland



Source: Rural Health Information Hub

The figure below shows metropolitan and nonmetropolitan deaths due to chronic lower respiratory disease from 2006 through 2015 per 100,000 population.

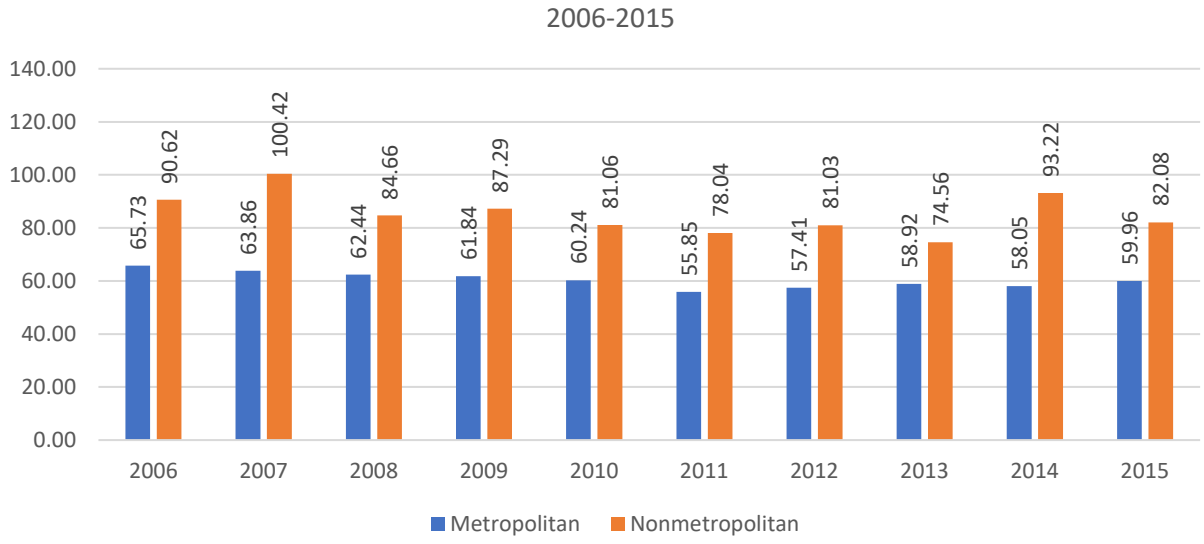
Figure 5: Deaths from CLRD for Metro and Nonmetro Counties — Maryland



Source: Rural Health Information Hub

The figure below shows metropolitan and nonmetropolitan deaths due to heart disease from 2006 through 2015 per 100,000 population.

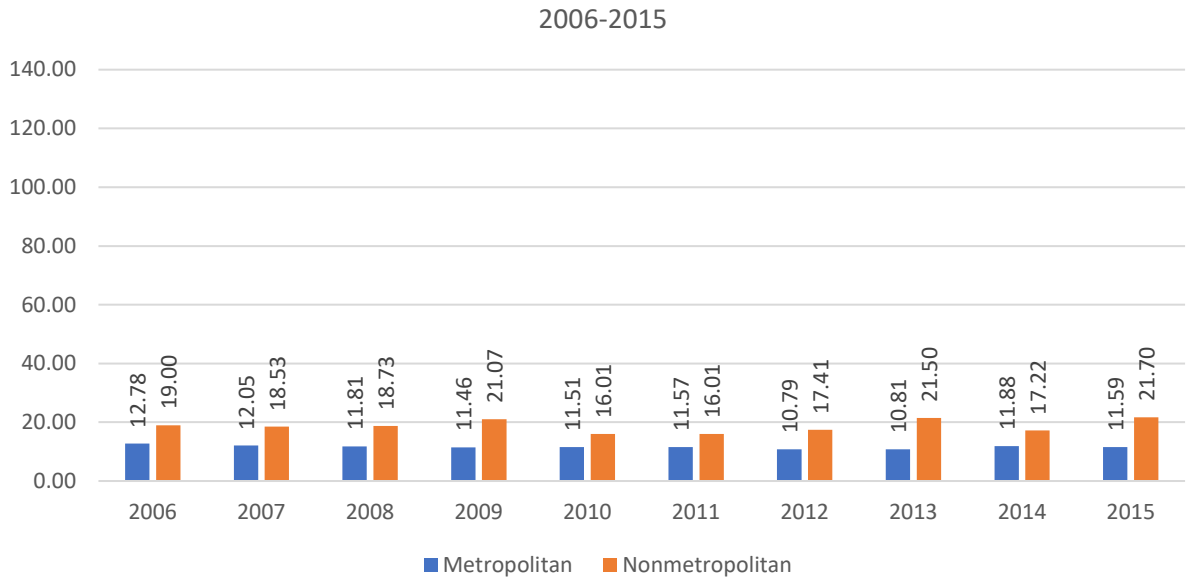
Figure 6: Deaths from Heart Disease for Metro and Nonmetro Counties — Maryland



Source: Rural Health Information Hub

The figure below shows metropolitan and nonmetropolitan deaths from a stroke from 2006 through 2015 per 100,000 population.

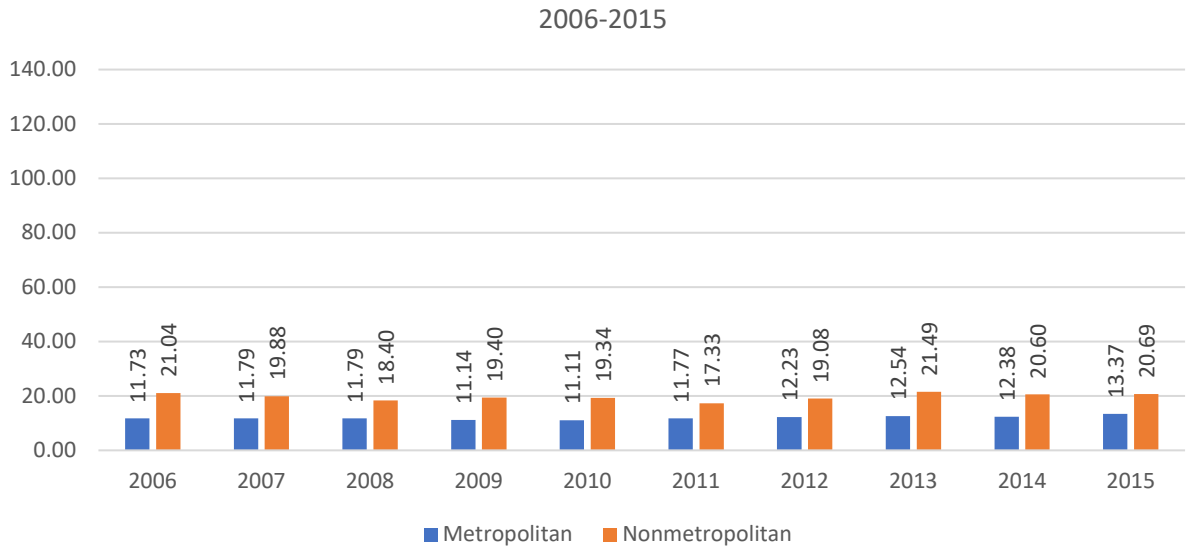
Figure 7: Deaths from Stroke for Metro and Nonmetro Counties — Maryland



Source: Rural Health Information Hub

The figure below shows metropolitan and nonmetropolitan deaths from unintentional injuries from 2006 through 2015 per 100,000 population.

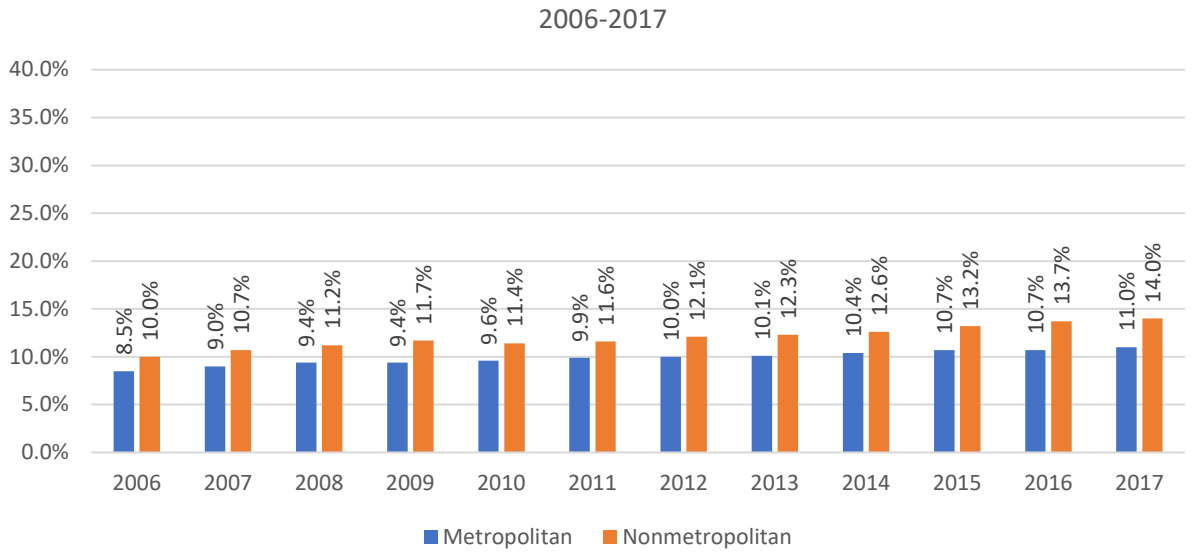
Figure 8: Deaths from Unintentional Injuries for Metro and Nonmetro Counties — Maryland



Source: Rural Health Information Hub

The figure below shows the metropolitan and nonmetropolitan portion of the population diagnosed with diabetes from 2006 through 2017.

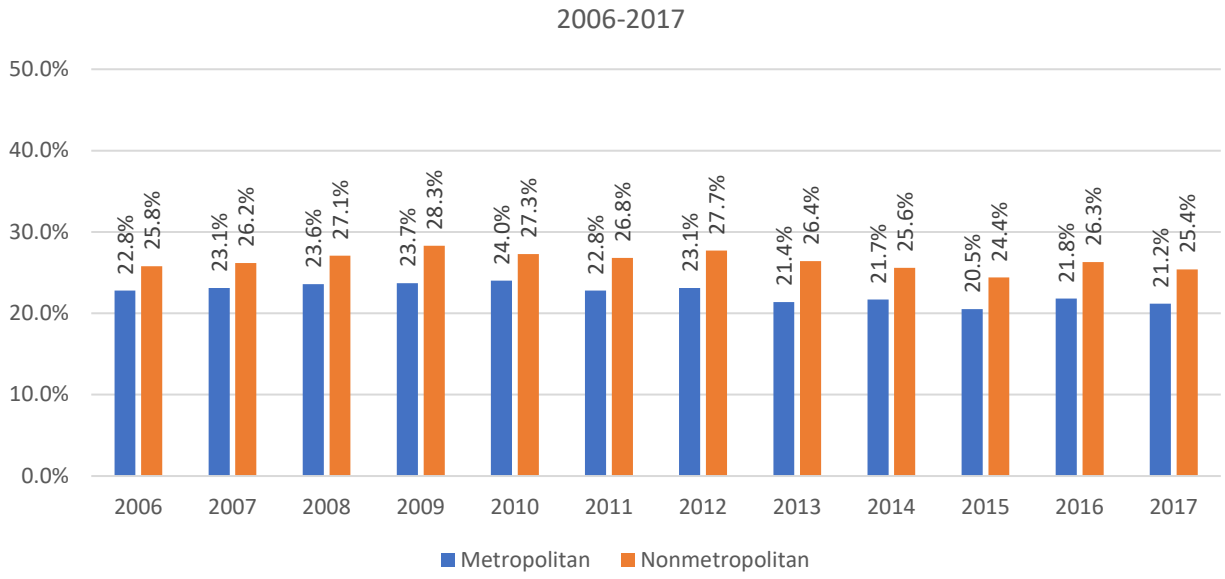
Figure 9: Diagnosed Diabetes Prevalence in Metro and Nonmetro Counties — Maryland



Source: Rural Health Information Hub

The figure below shows the percentage of the population that is physically inactive during leisure time for metropolitan and nonmetropolitan counties from 2006 through 2017.

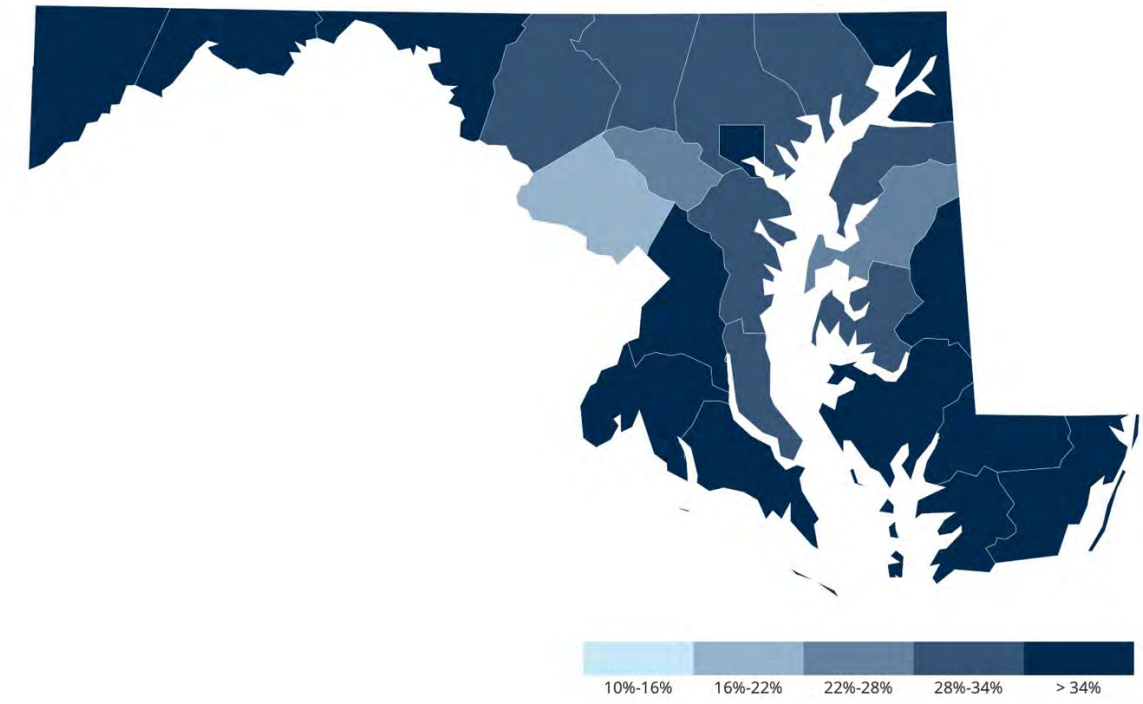
Figure 10: Leisure-time Physical Inactivity for Metro and Nonmetro Counties — Maryland



Source: Rural Health Information Hub

Map 11 shows county-level data on the proportion of the population that is obese.

Map 11: Obesity Prevalence, 2017



Source: Rural Health Information Hub

Table 12: County-level data of the population that is obese (Note: The below table corresponds with Map 11)

Location	Metro/Nonmetro	Percent Obese
Allegany	Metro	34.7
Anne Arundel	Metro	30.6
Baltimore	Metro	35.3
Baltimore City	Metro	31.3
Calvert	Metro	30.8
Caroline	Nonmetro	40.7
Carroll	Metro	30.3
Cecil	Metro	35.5
Charles	Metro	39.5
Dorchester	Nonmetro	40.6
Frederick	Metro	30.1
Garrett	Nonmetro	35.3
Harford	Metro	31.3
Howard	Metro	25.7
Kent	Nonmetro	30.2

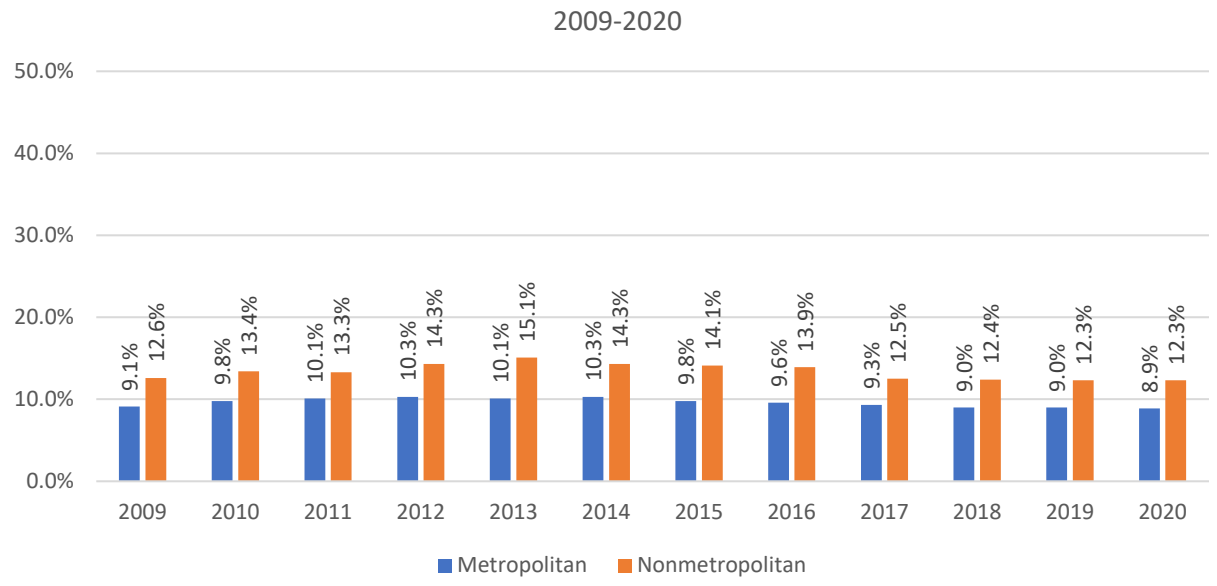
Location	Metro/Nonmetro	Percent Obese
Montgomery	Metro	21.
Prince George's	Metro	37.4
Queen Anne's	Metro	27.6
Somerset	Metro	42.0
St. Mary's	Metro	36.5
Talbot	Nonmetro	29.8
Washington	Metro	36.8
Wicomico	Metro	35.5
Worchester	Metro	36.3

Source: Rural Health Information Hub

Rural areas have an ongoing poverty problem. A 2014 Rural Policy Research Institute (RUPRI) publication reported counties with poverty rates above 20% over the past 50 years. Sixty-four percent of non-core (small rural) counties have persistent poverty, compared to 22% of micropolitan (large rural) and 14% of metropolitan counties. Rural areas have higher poverty rates, particularly among children and the elderly.[32]

The figure below shows the percentage of the population in poverty for metropolitan and nonmetropolitan counties from 2009 through 2020.

Figure 13: Poverty in Metro and Nonmetro Counties, Maryland

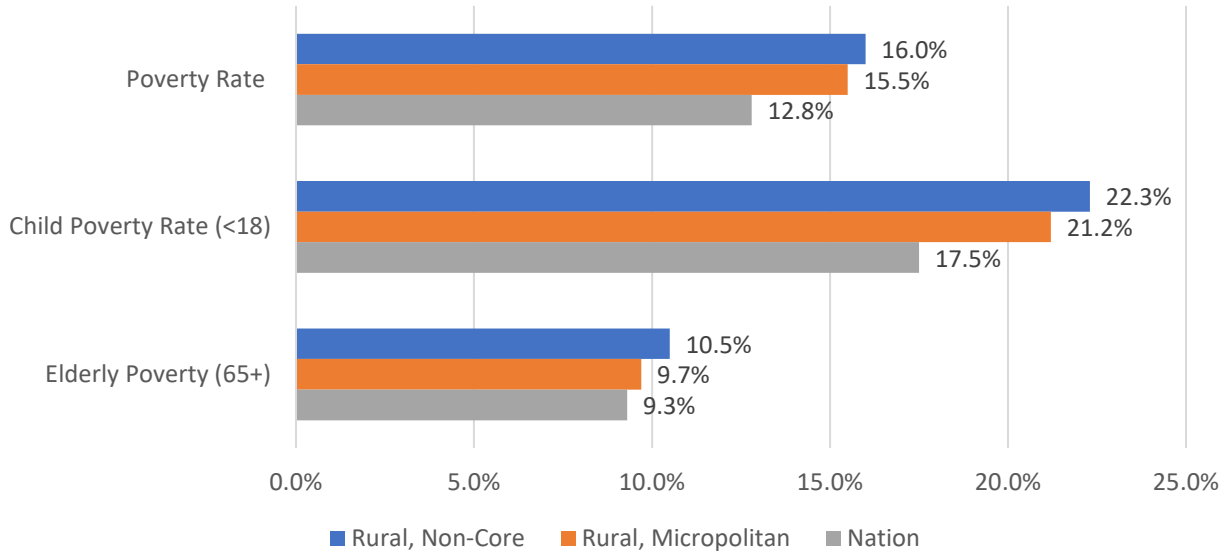


Source: Rural Health Information Hub

[32] Rural Health Information Hub

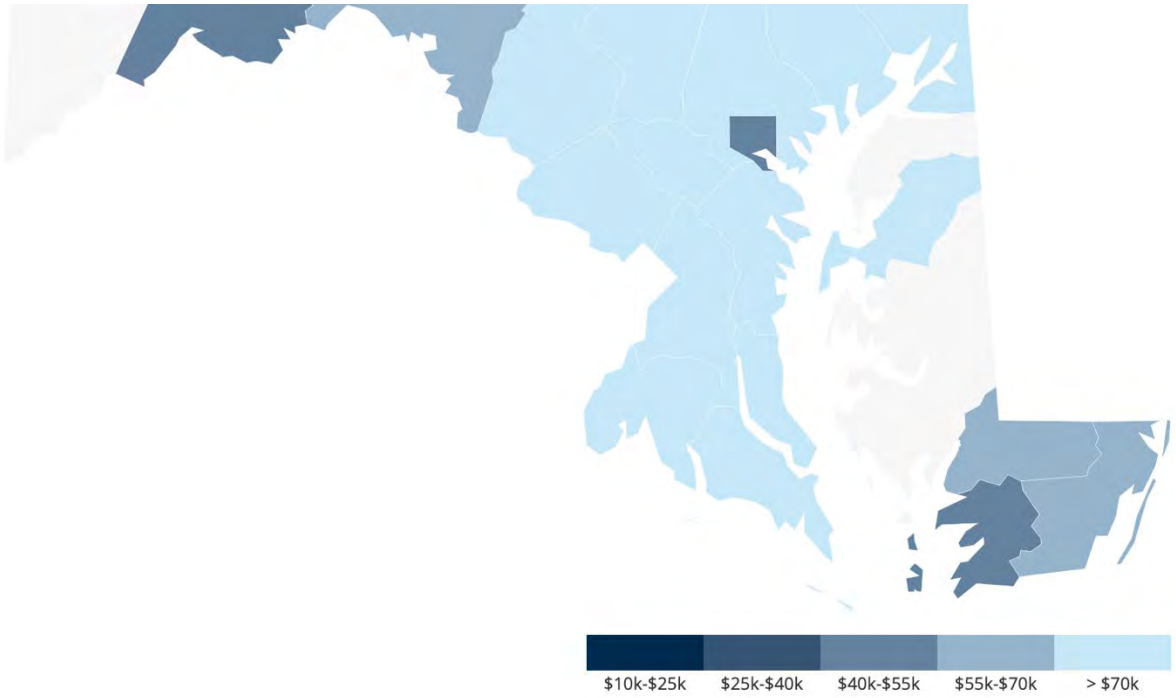
The average income is lower in rural areas. As reported by the U.S. Census Bureau, the nonmetro median household income in 2020 was $51,616, compared to $70,956 for the nation.

Figure 14: Rural Poverty Rates Nationally



Source: Rural Health Information Hub

Map 15: Median Household Income, 2020



Source: Rural Health Information Hub

Table 16: Median Household Income, 2020 (Note: The below table corresponds with Map 15)

Location	Metro/Nonmetro	Median Household Income
Allegany	Metro	$53k
Anne Arundel	Metro	$110k
Baltimore	Metro	$51k
Baltimore City	Metro	$80k
Calvert	Metro	$110k
Caroline	Nonmetro	$61k
Carroll	Metro	$100k
Cecil	Metro	$84k
Charles	Metro	$100k
Dorchester	Nonmetro	$55k
Frederick	Metro	$99k
Garrett	Nonmetro	$57k
Harford	Metro	$100k
Howard	Metro	$120k
Kent	Nonmetro	$64k
Montgomery	Metro	$120k
Prince George's	Metro	$85k
Queen Anne's	Metro	$93k
Somerset	Metro	$52k
St. Mary's	Metro	$110k
Talbot	Nonmetro	$69k
Washington	Metro	$63k
Wicomico	Metro	$59k
Worchester	Metro	$62k

Source: Rural Health Information Hub

A 2011 publication from the RUPRI identified eight demographic and four economic characteristics that indicate a community has high human service needs. Demographic indicators included the minority population, population 65 and older, veterans, adults without a high school diploma, and other factors. Economic indicators included poverty, households without vehicles, SNAP (food stamps) benefits, and income received from government transfer programs. Based on this set of 12 indicators, only 9% of metropolitan counties had three or more risk factors. In contrast, among non-metropolitan counties, 17.3% of micropolitan (large rural) and 31.2% of non-core (small rural) counties had three or more risk factors.[33]

HRSA developed shortage designation criteria and uses them to decide whether or not a geographic area, population group, or facility is a Health Professional Shortage Area (HPSA) or Medically Underserved Area / Population (MUA/P).[34] HPSAs may be designated as having a shortage of primary

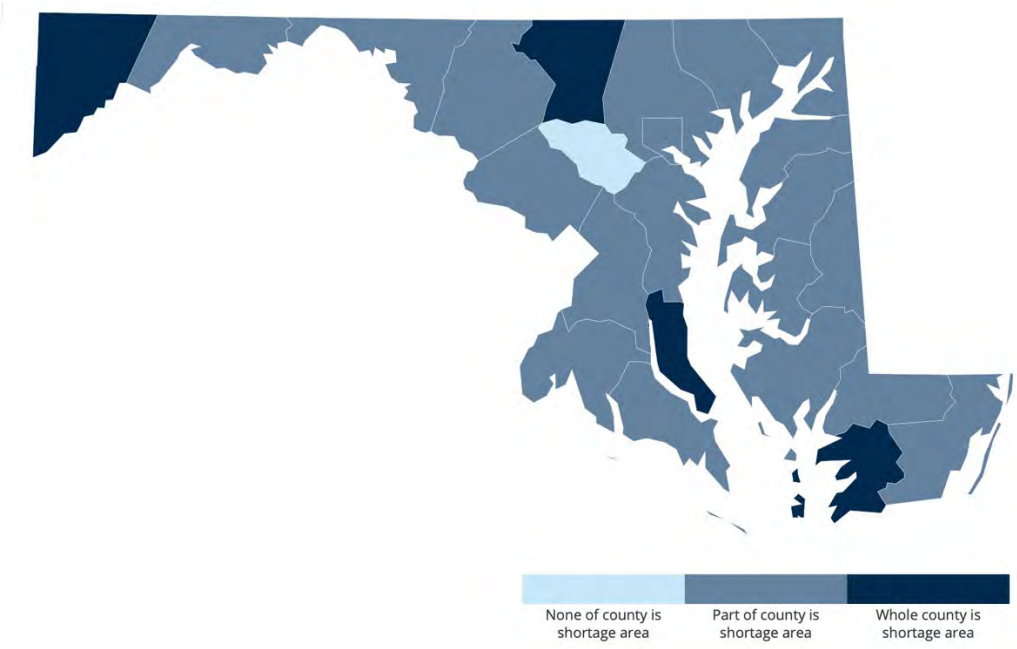
[33] Rural Health Information Hub

[34] Health Resources and Services Administration (HRSA)

medical care, dental or mental health providers. The criteria may include urban or rural areas, population groups, medical, or other public facilities. MUA/Ps are designated by HRSA as having too few primary care providers, high infant mortality, high poverty, and a large elderly population. An MUA may be a whole county or a group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts, in which residents have a shortage of personal health services. An MUP may be any group of persons facing economic, cultural, or linguistic barriers to healthcare.

One of the primary missions of developing a new medical school will be to train and retain qualified rural physicians in Maryland and to alleviate the current lack of adequate medical care, thereby improving access to primary care services. The map below reveals several counties in Maryland that qualify as an HPSA. The map indicates that several rural counties are completely medically underserved, while a majority of the counties in the state are partly underserved.

Map 17: Health Professional Shortage Areas: Primary Care 2022 — Maryland



Source: Rural Health Information Hub July 2022

Investments in Rural Health Care

Physicians practice where they are trained and creating a medical school in rural Northwestern Maryland can address the needs of many rural Marylanders. According to the American Academy of Family Physicians, family physicians who have a rural background and participate in rural tracts are more likely to choose to practice in rural areas.[35] The Journal of Rural Health reported that an eight-week rural rotation provided urban students with a positive experience of living and working in rural communities. Specifically, students showed significant interest in small towns after the rotation. [36]

In 2019, The Maryland School of Medicine received $750,000 in federal funds to train more physicians in rural communities as part of a $20 million award from HRSA. Investing in the future of rural health, several states and federal programs have legislation to assist in the investment.

- The National Health Service Corps' Loan Repayment Program repays the loans of primary care physicians in exchange for working — and earning a competitive salary — in rural, tribal, or urban communities with limited access to care.
- South Dakota has a recruitment assistance program that offers an incentive payment of $231,384 for qualifying physicians or dentists who make a three-year commitment to one of the state's community clinics and more than $66,000 for qualifying physician assistants, nurse practitioners, or nurse midwives.
- Alabama, which ranks in the bottom five states for health care, has several innovative programs, including scholarships, a rural physician tax credit, and early pipelines to the medical and health professions that target high school students.
- The federal Rural Physician Workforce Production Act would, if passed, provide funding so rural hospitals could hire more residents. Currently, 99% of graduate medical education funding goes to recipients in urban areas.
- The bipartisan Training the Next Generation of Primary Care Doctors Act would authorize nearly $650 million to train medical residents in low-income, underserved rural and urban neighborhoods over five years.

[35] American Academy of Family Physicians
[36] The Journal of Rural Health

National Outlook

Population Growth

The U.S. population is projected to increase by 79 million in the next four decades, from about 326 million in 2017 to 404 million by 2060. This corresponds to an average increase of 1.8 million people per year. The population is projected to cross the 400-million mark in 2058.[37]

A Growing Elderly Population

The nation's 65-and-older population is projected to nearly double in size in the coming decades, from 49 million in 2016 to 95 million in 2060.[38] Approximately 80% of older adults have at least one chronic disease, and 77% have at least two. Four chronic diseases — heart disease, cancer, stroke, and diabetes — cause almost two-thirds of deaths yearly. Additionally, the aging population will affect physician supply, as more active doctors will be older than 65 in the next decade.[39]

- Multiple chronic diseases account for two-thirds of all health care costs and 93% of Medicare spending. Only 1% of health dollars is spent on public effects to improve health toward chronic diseases, yet 75% of U.S. dollars are spent on health care dollars towards the ailment.
- 23% of the older population is affected by diabetes, or 12.2 million Americans aged 60 and older. Another 57 million Americans aged 20 and older have pre-diabetes, which increases a person's risk of developing Type 2 diabetes, heart disease, and stroke. In a Centers for Disease Control and Prevention program for people at high risk for developing diabetes, lifestyle intervention reduced risk by 71% among those 60 and older.
- 90% of Americans 55 and older are at risk for hypertension or high blood pressure. Women are more likely than men to develop hypertension, with half of women 60 and older and 77% of women 75 and older having this condition. Hypertension affects 64% of men aged 75 and older.
- Chronic diseases can limit a person's ability to perform daily activities, cause them to lose their independence, and result in the need for institutional care, in-home caregivers, or other long-term services and support.
- Specialist physicians are generally older on average than primary-care physicians, and they will be retiring in proportionately higher numbers.[40] Physician retirement could have the most significant impact on supply.

With the advancement of technology, people are improving their health outcomes and taking control of their chronic conditions by leading an active lifestyle, engaging in healthy behaviors, and obtaining preventative screenings; the demand for primary care and geriatric medicine will continue to grow.

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[37] U.S. Census Bureau
[38] Ibid.
[39] National Council on Aging
[40] Physician Supply Considerations: The Emerging Shortage of Medical Specialists: Merritt Hawkins, 2017

The Aging Physician

Another issue tied to physician shortages that are often overlooked is physician retirement. Across the United States, there are approximately 938,966 active physicians.

More than two of five currently active physicians will be 65 or older within the next decade. Shifts in retirement patterns over that time could have considerable implications for physician supply. Growing concerns about physician burnout, documented in the literature, and exacerbated by COVID-19, suggest physicians will be more likely to accelerate than delay retirement. On the other hand, economic uncertainty and any detrimental effect on physician wealth could contribute to delaying retirement.[41]

Improving access to care is imperative. COVID-19 has raised awareness of the disparities in health and access to care by minority populations, rural communities, and people without medical insurance. If underserved populations had health care use patterns like populations with fewer access barriers, demand would rise such that the nation would be short by about 102,400 (13%) to 180,400 (22%) physicians relative to the current supply.[42]

The Supply and Demand Imbalance for Physicians Across the United States[43]

The United States is facing a severe shortage of physicians, primarily because of the growth and aging of the population and the impending retirements of older physicians. Even though medical schools have increased enrollment by 30% since 2002, new data from the Association of American Medical Colleges (AAMC) predicts that the United States will face a shortage of 17,800, and 48,000 is projected by 2034. A lack of non-primary care specialty physicians of between 21,000 and 77,100 is projected by 2034, including:

- Between 15,800 and 30,200 for Surgical Specialties.
- Between 3,800 and 13,400 for Medical Specialties.
- Between 10,300 and 35,600 for the Other Specialties category.

In 2018, there were 277.8 active physicians per 100,000 in the United States, ranging from a high of 449.5 in Massachusetts to a low of 191.3 in Mississippi. The states with the highest number of physicians per 100,000 population are concentrated in the Northeast.[44]

The Increased Effect of COVID-19 on Physician Shortages

The number of U.S. physicians who left the workforce in early 2019 and into the fall of 2021, even before the pandemic crashed into emergency room departments and left physicians feeling distraught due to misinformation and public mistrust, was problematic. In April 2020, roughly 1.5 million health

[41] Association of American Medical Colleges: State Physician Workforce Data Book 2021
[42] Ibid.
[43] Ibid.
[44] Association of American Medical Colleges, 2019 State Physician Workforce Data Book

care workers lost employment as health care clinics and urgent centers closed, and hospitals postponed surgeries and other non-emergency procedures to limit the spread of the virus. By the fall of 2020, many of these jobs returned, but health care employment still lagged at 2.7% pre-pandemic levels.[45]

The AAMC stated that COVID-19 would likely have significant consequences for the nation's physician workforce, including changes in the specialties physicians choose, the educational pipeline, licensure, reimbursement regulations, how medicine is practiced, and workforce exit patterns. The COVID-19 pandemic has already highlighted shortages in specialty physicians, especially those with hospital-based specialties such as critical care, pulmonary care, and emergency medicine.[46]

As a result of the profound disruption COVID-19 placed, The Physicians Foundation focused their survey solely on the pandemic. The survey found that 8% of physicians had closed their practices.[47] With more than 200,000 medical practices in the United States, about 16,000 had closed. Another 4% of doctors planned to close shop within 12 months. The survey revealed that 61% of physicians often reported feelings of burnout, showing a significant increase since 2018. The closing of practices raised the threat of an even greater physician shortage than expected.[48]

Addressing the shortage will require multiple approaches, including innovation in care delivery, greater use of technology; improved, efficient use of all health professionals on the care team; and an increase in federal support for residency training.[49] The projected shortfall is significant enough that no single solution will be sufficient to resolve physician shortages.

The AMA has long advocated expanding graduate medical education (GME) and adding significant numbers of residency training positions. The AMA supports the bipartisan Resident Physician Shortage Reduction Act of 2021 (S. 834/H.R. 2256) to address the physician shortage. The approved ruling would provide 14,000 new Medicare-supported GME positions.[50] MSOM development will be implemented in parallel with GME expansion locally to respond to these shortages across the spectrum.

Positive Perception of Health Care Heroes[51]

The pandemic disrupted many students' plans and caused many to reconsider their educational and career options. However, considering the changing health care and social injustice landscape, in 2020, medical schools reported more interest in the field. According to the AAMC, the number of applications to medical schools across the country increased by 18% in 2020. Boston University School of Medicine reported applications were up 27%, to 12,024 for about 110 seats. Stanford University School of Medicine reported a 50% jump in the number of applications, or 11,000 applications for 90 seats.[52]

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[45] American Medical Association
[46] Association of American Medical Colleges; Physician Supply and Demand — A 15-Year Outlook: Key Findings
[47] Ibid
[48] The Physicians Foundation Survey
[49] Ibid
[50] American Medical Association
[51] Forbes Magazine
[52] National Public Radio (NPR)

The surge in applications is due to what admissions officers and industry professionals believe are examples set by medical workers and public health figures like Dr. Anthony Fauci, Director of the National Institute of Health and Infectious Diseases. Dr. Fauci sees the flood of medical school applicants as a sign that people are thinking about social injustice. The onslaught of medical misinformation led to public health measures becoming politicized, and health care workers became subject to abuse and harassment. People have witnessed the challenges that health care workers face along with the social injustices stoking and fanning interest in the medical field.

The increased applications may also be related to changes in medical school admissions requirements as some schools dropped the Medical College Admission Test examination requirement or shifted back application deadlines. Nonetheless, the overall interest in the field may assist with the growing physician shortage.

Clinical Training

Clinical Landscape

Obtaining clinical experiences is an essential part of students preparing for their profession. The clinical experiences and knowledge gained will be viewed by admissions officers looking at the student's health care experiences as an essential part of their holistic review.

Maryland is home to 72 hospitals, of which 13 are government hospitals, and two are private health care facilities.[53] This geographic region does not have a critical access hospital; however, it has 24 Federally Qualified Health Centers (FQHCs) and one rural health clinic.[54]

The abundant hospitals and health systems are favorable for clinical partnerships and collaborations, allowing for ample medical opportunities for students to obtain clerkships and residency training. Maryland can provide significant training opportunities for the proposed osteopathic medical school.

Appendix H identify these hospitals, health systems, FQHCs, and Look-Alikes in Maryland. These sites may offer additional opportunities for students to obtain clerkships and residency training.

Clerkship Opportunities

The accessibility of clinical spots is imperative to the medical school's success. An important factor in determining the feasibility of a new medical school is the number of clinical encounters at nearby hospitals and within the outpatient environment at private practices and community health centers. Student placement in a medical setting must be well-positioned and established, and formal relationships with regional partners are critical. The proposed MSOM is appropriately positioned to work collaboratively with clinical organizations to sufficiently place students for clerkship opportunities.

[53] Maryland Government
[54] Rural Health Information Hub

To ensure a feasible project, a high degree of commitment must be present among all regional hospitals to support the educational training needs of third- and fourth-year medical students.

The proposed osteopathic medical school will leverage the strengths of multiple clinical partners throughout the region to train physicians to provide team-based, interprofessional patient care to prevent and treat complex and chronic diseases. With the ability to provide learning experiences with clinical partners throughout Maryland, the new medical school will have access to clinical partners throughout the state.

Tripp Umbach's analysis of hospitals across Maryland and in contiguous states indicates that clinical activity is adequate to support the education of 180 medical students per class (at maturity).

Graduate Medical Education (GME) Planning

Medical residency is postgraduate training for physicians. In addition to clerkship training during medical school, medical students must complete a residency training program after graduating. Fourth-year medical students will explore the medical specialty they want to explore, and they may apply to several medical residency programs that feature that specialty. It is typical for residents to practice in the area in which they complete their residency training.

Addressing the physician shortage requires a multi-pronged approach, including increasing federal support for GME, which until December 2020 remained effectively frozen since 1997. As the rate of medical school enrollment increases, it is crucial to monitor and support GME initiatives as both components are intertwined. Data from the AAMC Medical School Enrollment reported that half of the medical schools are concerned about their incoming students' ability to find a residency training position of their choice upon completion of medical school, and federal caps on Medicare-funded residency training positions remain effectively frozen at 1996 levels. The AAMC supports the Resident Physician Shortage Reduction Act of 2021 (S. 834, H.R. 2256), which would add 14,000 residency slots over seven years.[55] In addition to expanding support for federally funded residency training positions, non-GME incentives and programs, such as Conrad 30, the National Health Service Corps and Public Service Loan Forgiveness, and Title VII/VIII, are used to recruit a diverse workforce and encourage physicians to practice in shortage specialties and underserved communities. [56]

The COCA's accreditation Standard 10 addresses GME by stating that: [57]

- The faculty at the College of Medicine (COM) must ensure that the curriculum provides the content of sufficient breadth and depth to prepare students for entry into a graduate medical education program for the subsequent practice of medicine. The COM must strive to develop graduate medical education to meet the needs of its graduates within the defined service area, consistent with the mission of the COM:

[55] Association of American Medical Colleges
[56] Ibid
[57] Commission on Osteopathic College Accreditation: Accreditation of Colleges of Osteopathic Medicine: COM Continuing Accreditation Standards

- A COM must demonstrate its policies, procedures, personnel, and budgetary resources to support the continuum of osteopathic education.
- A COM must provide a mechanism to assist new and existing graduate medical education (GME) programs in meeting the requirements for accreditation by the Accreditation Council for Graduate Medical Education (ACGME).
- A COM must provide a mechanism to assist graduate medical education programs accredited by the ACGME in meeting the requirements of osteopathic recognition.
- A COM must demonstrate and publish publicly the placement of its students in graduate medical education programs, including through the publication of placement rates of its students.

The MSOM can work collaboratively with health care institutions to develop GME. Regional stakeholders and key investors, from government leaders to health care institutions, report the opportunity to provide training to medical students. Executive leaders at the MSOM will continue to visit hospitals, physician groups, and health care institutions throughout the state to broaden and deepen collaboration for medical education.

There are several advantages and benefits GME brings, including recruitment cost savings, revenue generation from increasing physicians and residents; workforce alignment; and community-based training sites that can improve health status, decrease costs, and facilitate inter-professional care.

Residency Match Rate[58]

The 2022 Residency Match included 47,675 registered applicants and a record 39,205 certified positions. The 2022 Main Residency Match had 39,205 total positions, the largest number on record. Of those, 36,277 were first-year (PGY-1) positions, the largest on record and a 3.1 percentage point increase over last year. The growth in PGY-1 positions was supported in part by the rise in the number of programs offering PGY-1 positions, 177 or 3.4 percent, in the Match.

The 2022 Main Residency Match saw a record number of positions offered in primary care. Of the 36,277 first-year positions offered, 18,133 (50.0%) were in Family Medicine, Internal Medicine (categorical), Medicine-Pediatrics, Medicine – Primary, Pediatrics, and Pediatrics – Primary, an increase of 484 positions (2.7%) over the number offered in 2021.

Of the primary care positions offered in the 2022 Main Residency Match, 17,116 (94.4%) were filled, and 11,061 (64.6%) were filled by U.S. seniors. Although the percent of primary care positions filled by U.S. seniors in 2022 represents a slight decline (0.7%) from the prior year, U.S. D.O. seniors saw a gain in number matched in Family Medicine (54 positions, 3.6% increase), Internal Medicine (120 positions, 8.1% increase) and Pediatrics (61 positions, 11.8% increase) in 2022.

[58] The National Resident Matching Program®

Projected Revenues, Expenditures, and Cash Flow

The MSOM has a favorable proforma demonstrating this project's financial viability. Positive cash flow and margins when the college graduates its first class provides a strong measure of sustainability. This project's projected annual operating revenue for the first cohort of student graduates is roughly $37.5 million.

For the analysis, Tripp Umbach reviewed the most current financial models for the proposed MSOM. The MSOM provided Tripp Umbach with the financial model, including all assumptions, operating and capital expenditures, projected revenues, and financing scenarios. Tripp Umbach reviewed every input of the model, benchmarking values to industry standards and comparing them to Tripp Umbach's historical experience and expertise.

The financial team for the MSOM completed their due diligence on this project and examined external market conditions and local and regional market conditions affecting rural Northwestern Maryland.

Our due diligence with the financial analysis has concluded the following:

1. The project is financially viable for the institution in the near, mid-range, and long term.
2. The proposed COM will have a long-term positive cash flow and margin.
3. The short-term negative cash flow will be manageable for the organization and financially prudent considering the long-term margin gains.
4. While some inherent risks are associated with any new educational endeavor, the historical performance of COMs suggests a good risk/benefit analysis.

Economic Impact

Tripp Umbach's national studies estimate that medical schools and teaching hospitals generate more than $800 billion annually in the U.S. economy. The establishment of a new osteopathic medical school campus at Meritus Health in Hagerstown, Maryland, will bring significant revenue to the region and is likely to inspire additional economic development through the potential expansion of other health science education programs, clinical and research partnerships with nearby community hospitals, and private business expansions that may be developed over time.

The proposed MSOM will bring economic benefits directly and indirectly to Washington County and the state of Maryland. The direct benefits will come from the direct spending of the proposed medical school campus on capital improvements and goods and services to businesses in the region, the hiring of new faculty and staff, and through student spending. The indirect impact is derived from these direct, first-round expenditures, which are received as income by other regional and state businesses and circulated through the economy in successive rounds of spending.

In June 2022, Tripp Umbach conducted a study to quantify the projected annual economic, employment, government revenue, and social impacts associated with the proposed MSOM in Hagerstown, Maryland,

at the time of the first class being welcomed on campus in 2025, as well as that classes graduation in 2029 when the campus will be viewed as fully operational. This study also demonstrates the future economic impacts of the school in 2032 and 2040 when the college has additional programs and has graduated a significant number of physicians and other health care professionals.

Tripp Umbach is the national leader in developing economic impact statements for medical schools, having completed studies since 1995 for every allopathic medical school and more than half of all osteopathic medical schools. Over the past 30 years, Tripp Umbach has conducted economic impact studies for more than 30 new or expanded medical schools, including studies for 15 new medical schools that are now operational. The economic, employment, and government revenue numbers presented in this report are based on projected spending data provided to Tripp Umbach by the MSOM and the historical achievement of existing medical schools.

Direct Benefits of Graduate Medical Education (GME) to Hospitals and their Communities

GME is a critical resource for the future of health care in the United States. Studies have shown that increases in the primary health care delivery model are tied to better patient health outcomes, lower costs for health providers, and greater equity in health. To increase the primary-care delivery model in rural areas in Maryland, physicians must be trained in primary-care disciplines and select shortage specialties such as family practice, general community-based internal medicine, pediatrics, and psychiatry.

Maryland can increase its primary-care physician pool by expanding and developing new postgraduate residency positions in underserved rural areas statewide. As more students are trained in primary-care fields throughout the country, their impacts on the communities they serve are felt.

Hospitals with residency programs are stronger financially, provide significantly more accessible care, have higher-quality scores, and offer a broader range of services than similarly sized hospitals without residency programs.

- More Doctors: Residency programs can lead to the recruitment of additional sub-specialty physicians who train medical students and provide sub-specialty clinical services that were not available in the community before the formation of the residency program.
- Cost Savings to Taxpayers: The typical hospital with a residency program in internal medicine saves approximately $3.4 million each year in uncompensated care.
- Strong Hospitals: Hospitals save $75,000 on average in recruitment costs for every resident they hire – allowing these dollars to be invested in patient care and community health programs. Hospitals with primary-care residency programs have lower utilization of emergency departments due to clinics that residents will staff.
- Patient Care Quality: Outpatient services provided by residency programs include school-based programs, screenings, community-based education programs, nursing home support, medical home health care support, emergency department follow-up, and support for public health departments.

- Partner Benefits: Academic medical centers benefit from funding associated with primary-care access-related research.
- Resident Benefits: Residents who remain in the community have a strong working knowledge of the local and regional health care environment and are better able to direct the care of their patients.
- Family physicians are significant generators of economic activity in local communities on top of the health care services they provide. Family physicians employ staff, purchase goods, and services, and generate income for other health care organizations in their community (e.g., hospitals and nursing homes).

Economic Impact of the Proposed Meritus School of Osteopathic Medicine

- In 2029, when the proposed school is fully operational, it will have an economic impact (direct and indirect economic benefits) of $120 million, 622 jobs, and $4.7 million in taxes to communities in the region.
- In addition to the operational impact outlined above, by 2032, the economic impact of the proposed campus will grow to $128.4 million as communities in Washington County will begin realizing health care benefits and additional economic impact as graduates of the campus located in the region and state.
- Tripp Umbach estimates that by 2032 when the first class of medical students completes their residencies, these new primary care physicians will also yield actual savings, as emergency room utilization declines, for example. These health care savings are expected to total $142.6 million annually by 2032 when 14 graduates from the program remain in rural Maryland to practice. Total health care cost savings by 2040 generated by graduates of MSOM will equal more than $1.1 billion.
- By 2040 commercial spin-off activity from research completed at the proposed campus will equal $45.0 million annually.
- By 2040 the total economic impact of the proposed school of medicine in the Hagerstown region will equal more than $1.7 billion, support over 9,000 jobs, and contribute more than $153.0 million to state and local governments.

Table 18 summarizes total economic, employment, and government revenue impacts. All numbers are presented on an annual basis for the years listed. For example, health care cost savings are calculated for the year in which a class of expected graduates enters the practice of medicine.

Table 18: Summary of Projected Regional Impacts

	2025	2029	2032	2040
Annual Operational Impacts	$46.0 M	$120.0 M	$128.4 M	$180.0 M
Workforce Impacts	-	$156.0 M	$166.9 M	$1.5 B
Private Spin-Off Impacts	-	$26.4 M	$33.4 M	$45.0 M
Total Economic Impact	$46.0 M	$302.4 M	$328.7 M	$1.7 B
	2025	**2029**	**2032**	**2040**
Healthcare Cost Savings	-	-	$142.6 M	$1.1 B
Total Direct Jobs Supported	163	429	434	9,360
Regional Government Revenue	$24.0 M	$7.0 M	$16.0 M	$153.0 M

Note: The chart above does not include investments and impacts from additional construction over 2023-2045.

Additional Economic and Societal Benefits

An osteopathic medical school in Hagerstown, Maryland, would have a positive and encouraging effect on the delivery of health care services, improved patient outcomes, and the making of a strong regional economy. The proposed college of osteopathic medicine could be a significant driver of the economy, creating jobs and generating millions in annual net impact to the region. The planned school of medicine could also:

- Increase health care access for rural underserved and disenfranchised populations.
- Increase the number of highly qualified rural physicians with regional connections and interests, addressing the region's health care workforce needs.
- Expansion of an innovative economy whereby biomedical companies are launched in and attracted to the region; new jobs are created; and research sparks technology transfer, commercialization, and economic value through improvements in prevention, treatment, and practice.
- Grow the health care delivery system in Maryland. As a result, the quality of life for community residents improves, and the ability to leverage health care cost savings.

Additional Impacts not included in the Study

Tripp Umbach's analysis of the economic impact of the proposed MSOM in Hagerstown is based on many conservative assumptions. Not included in this analysis are the economic impacts associated with the growth of the regional health care industry related to additional patients staying in the region for

care, patients being attracted to the region for care due to increased quality and expanded medical services, or the economic benefits related to the expansion of graduate medical education at local hospitals.

Economic Impact Methods and Notes

Tripp Umbach completed an economic impact assessment of the proposed MSOM on the campus of Meritus Health in Hagerstown, Maryland. Tripp Umbach has performed more than 500 economic impact studies for academic institutions and large health care systems, including for every U.S. medical school and more than 400 teaching hospitals – allopathic and osteopathic institutions. The economic models used by Tripp Umbach in this analysis were first developed in 1970 by the American Council on Higher Education. The data in the model were supplied by the MSOM (faculty, students, operational expenses, etc.) and from Tripp Umbach's comprehensive database and models from new medical school and existing medical school expansion studies in other localities throughout the United States. The methodology employed in these studies was initially derived from a set of research tools and techniques developed by the American Council on Education (ACE).[59] The ACE-based methodology employs linear cash flow modeling to track the flow of institution-originated funds through a delineated spatial area. Based on previous economic impact studies performed for new and/or regional medical schools throughout the United States and the State of Maryland.

Applying this "fresh dollar" model provides a first-line measure of the state economy caused by the proposed MSOM. The final model concept evolved into a hybrid model, including a fresh-dollar approach feeding into a traditional model which tracks in-state and in-region spending. The final model used for this research measures funds brought into the state with the ultimate flow of these funds through the Maryland and Hagerstown regional economies and the effect on economic expansion, job growth, and government revenue and enterprise development. The final methodology closely matches the impact study methodology recommended by the Association of American Medical Colleges (AAMC) for individual medical schools.

Conclusion

Rural Maryland needs more physicians and a commitment from health care facilities, statewide medical schools, physicians, and community organizations is required to develop a new osteopathic medical school that attracts Maryland students from rural backgrounds. One proactive step is to increase the number of students from rural areas and committed students to rural and family practice, in addition to implementing rural-based curriculum/tracks in all medical schools. Residency programs are needed to teach the clinical, social, interpersonal, and management skills required for successful rural practice.[60]

[59] Caffery, John and Issacs, Herbert, "Estimating the Impact of a College or University on the Local Economy," American Council on Education, 1971.
[60] American Academy of Family Physician

Today's medical schools face challenges producing physicians committed to practice in rural communities. More than 200 medical schools and regional campuses in the U.S. currently offer D.O. or M.D. degrees, many without a rural training track program. It is essential that medical education shift its focus to creating rural training tracks in conjunction with other state-wide medical schools to address the growing needs of the millions of rural residents who need essential health care services.

The benefits of a proposed school of osteopathic medicine in rural Maryland will be beneficial to the community as regional stakeholders offer full support. A proposed osteopathic school of medicine would be complimentary to the Maryland College of Osteopathic Medicine (MDCOM) at Morgan State University, other state hospital and health systems, higher education institutions, clinical organizations, and community health care facilities provided by rural physicians to improve and maintain better population health.

To resolve America's rural health care shortage, medical schools must create more programs to showcase the attraction of rural living and provide financial incentives to attract and retain physician talent to communities of need, supporting legislation at the federal, state, and local levels to provide rural residents with the necessary health care. Changes in Medicare and Medicaid payment policies that result in more equitable payments to rural hospitals and physicians can positively affect the retention of family physicians.[61]

The osteopathic medical school will seek to train high-quality physicians matching in all specialties to practice in rural communities in Maryland and surrounding states. Increasing the poll of physicians to practice in rural Maryland in primary care, population health improvement, and other specialties, the MSOM will secure financial support and participation from education partners, Meritus Health, other health care institutions, and industry partners. Addressing key factors, the MCOM should be successful in opening a premier and sustainable osteopathic medical school that meets the needs of the next generation of learners, teachers, health care delivery systems, and, most importantly, patients.

[61] American Academy of Family Physician

Appendix A: Project Overview

In June 2022, the proposed Maryland School of Osteopathic Medicine at Meritus Health contracted with Tripp Umbach to complete a feasibility study to assess and evaluate the opportunities and benefits of expanding medical education in the state of Maryland, specifically examining the development of an osteopathic medical school in Hagerstown, Maryland. The Tripp Umbach team gathered feedback from Meritus Health and assessed the primary care and statewide/regional markets to provide key findings and recommendations for the proposed medical school.

- **Project Planning and Work Sessions:** Tripp Umbach worked with leadership from the MSOM to lay out the study's goals and to understand the vision for the proposed medical school. Discussions with leadership allowed Tripp Umbach to identify opportunities and challenges associated with developing an osteopathic medical school in Hagerstown, Maryland. To complete the study, Tripp Umbach conducted the following:
- **Independent Financial Analysis Review:** Tripp Umbach independently reviewed preliminary estimates of expenses and revenues, faculty, and staff for the campus for the start-up and the first five years of operations. Tripp Umbach reviewed the projected annual operating budget during development and at maturity. The financial analysis will be based on the MSOM's current medical school operations and Meritus Health's vision for the school of medicine. The analysis will comply with the requirements of the Commission on Osteopathic College Accreditation.
- **Economic and Social Impact Analysis and Statement:** Tripp Umbach provided a statement of potential economic impacts of the proposed campus using the estimates of budget and class size determined most feasible. The economic impact discussion illustrated the short- and long-term benefits and measurement within the community surrounding Meritus Health.
- **Feasibility Analysis:** Tripp Umbach developed an independent report of key elements required to demonstrate the need and feasibility for an osteopathic medical school campus in Hagerstown, Maryland, on the campus of Meritus Health that complies with the requirements of the Commission on Osteopathic College Accreditation (COCA). The assessment included the following: physician needs, student supply and demand, clinical training supply and interest in providing teaching for medical students, and opportunities for Graduate Medical Education (GME) for medical students. Tripp Umbach's social impact analysis will focus on expanding the rural physician workforce in underserved areas and the benefits associated with population health improvement.
- **Environmental Scan:** Tripp Umbach developed an independent report to demonstrate the need to increase rural physicians in Maryland to address the needs of the patient population living in underserved communities. The assessment focuses on the vision for the MSOM to train high-quality rural physicians who can match into all specialties of medicine, not only primary care.

- **Development of Final Report:** Tripp Umbach developed a final independent report to be used by the MSOM to guide further evaluation and planning efforts and to continue to explore the development of an osteopathic medical school.

Appendix B: Mission and Vision of the Proposed Maryland School of Medicine

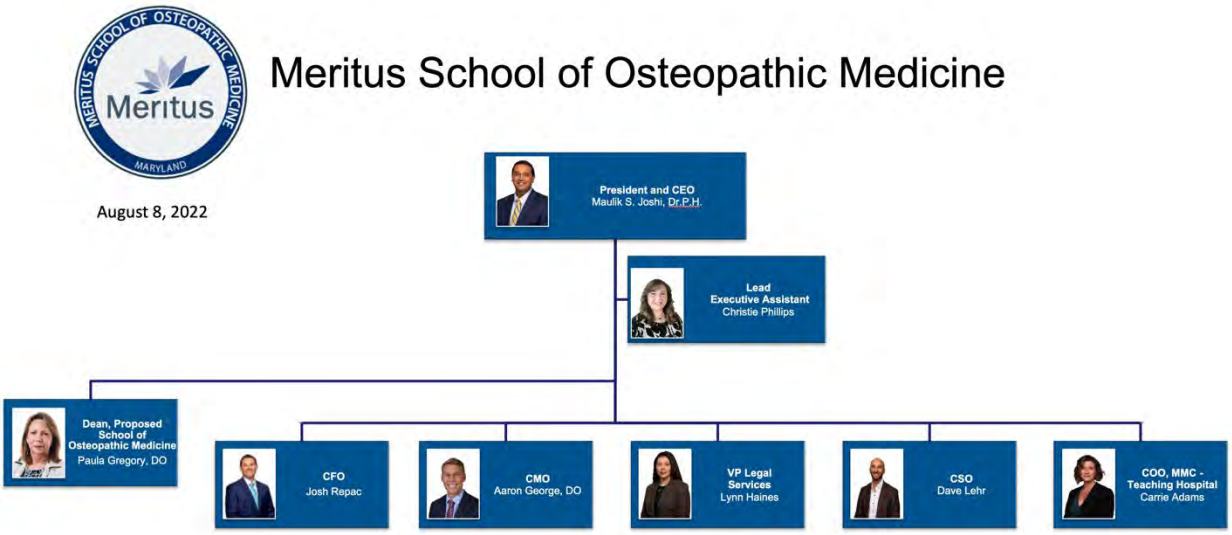
Mission and Vision

Vision: To be a leader in community-based medical education.

Mission: Prepare future generations of physicians who are professionally accomplished, socially responsible, and community oriented.

Appendix C: Organization Chart of the Proposed Maryland School of Medicine

The below figure is the proposed organization chart for the MSOM.



Appendix D: Critical Access Hospitals and Rural Health Clinics

The Critical Access Hospital (CAH) program is a federal program established in 1997 as part of the Balanced Budget Act. The program aims to help small hospitals in rural areas serve residents who would otherwise be a long distance from emergency care. To accomplish this goal, CAHs receive certain benefits, such as cost-based reimbursement for Medicare services. As of January 2022, Maryland and Delaware do not have any CAH.

The Rural Health Clinic (RHC) program is intended to increase access to primary care services for patients in rural communities. RHCs can be public, nonprofit, or for-profit health care facilities. To receive certification, they must be located in rural, underserved areas. The clinic must be staffed at least 50% of the time with an N.P., PA, or CNM. RHCs are required to provide outpatient primary care services and basic laboratory services. As of January 2022, Maryland has one RHC.

Appendix E: Addressing Rural Health Needs in Maryland

A 2017 report titled "Transforming Maryland's Rural Health Care System: A Regional Approach to Rural Healthcare Delivery" by a Workgroup on Rural Health Delivery to the Maryland Health Care Commission recommended ways to support and enhance health care in Maryland's rural counties.[62]

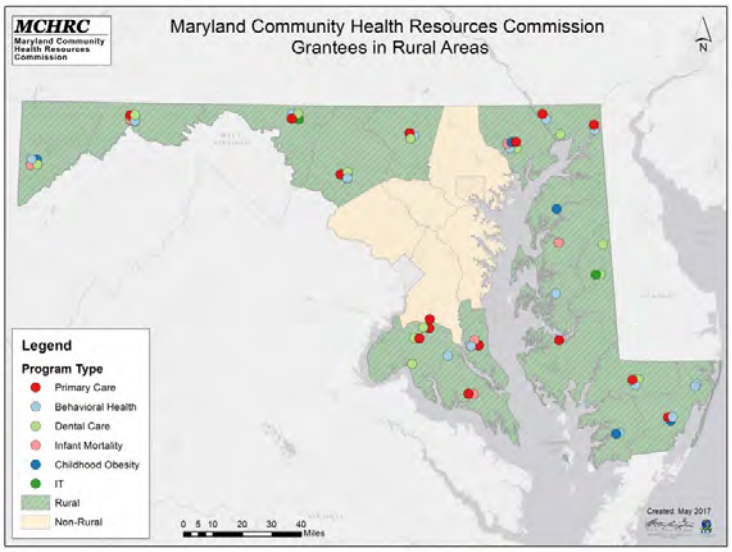
The list of recommendations in the report includes ways to:

1. Expand the rural healthcare workforce
2. Increase rural residents' access to care
3. Fund economic development
4. Address vulnerable population needs

Addressing poor health outcomes in rural Maryland, The Maryland Department of Health – Maryland Community Health Resource Commission (CHRC) promotes rural health and expands access in underserved communities. To date, the commission has awarded 347 grants totaling $85.9 million. Close to half (148 of 301) are programs geared explicitly towards rural areas. CHRC rural health grants, which total approximately $37.9 million, have provided more than 104,000 patients access to primary care, behavioral health care, dental, women's health, and childhood obesity prevention services in 18 rural jurisdictions of the state. CHRC grants have provided start-up funding to enable safety net providers to increase their capacity. They have supported innovative and replicable projects to address social determinants of health and serve vulnerable populations.[63]

Map 19 displays the grants by program type within the state.

Map 19: Maryland CHRC Grantees in Rural Areas



[62] According to local health officers, few of the 2017 report's recommendations received legislative attention. Specific recommendation can be found in the report.

[63] The Maryland Department of Health – Maryland Community Health Resource Commission

Appendix F: Regional Profile of Washington County, Maryland

Maryland Population Data

Maryland covers 9,774 square miles, with a 2020 estimated population of 6,177,224 people – with 151,354 people living in rural areas. According to 2021 data from the U.S. Census Bureau, an estimated 58.5% of the state's population is white, 31.1% is African American, 6.7% is Asian, 0.6% is American Indian or Alaska Native, 0.1% is Native Hawaiian or Other Pacific Islander, and 10.6% is of Hispanic or Latino origin.[64]

According to the Economic Research Service, rural Maryland residents' average per capita income in 2020 was $57,714.[65]

The ERS reports that the poverty rate in rural Maryland is 12.3%, compared with 8.9% in urban areas of the state. The unemployment rate in rural Maryland is 5.2%, and in metropolitan Maryland, it is 5.8%. 11.6% of the rural population has not completed high school, while 9.4% of the urban population lacks a high school diploma (2016-2020).[66]

Demographics[67]

- The 2020 population estimate for Washington County was 150,575, of which 97.79% are citizens.

Race

- In 2020, there were 7.28 times more White (non-Hispanic) residents (117k people) in Washington County, MD, than any other race or ethnicity. There were 16.1k Black or African American (Non-Hispanic) and 5.64k Two+ (non-Hispanic) residents, the second and third most common ethnic groups.
- 5.43% of Washington County, MD's people are Hispanic (8.17k).
- As of 2020, 4.98% of Washington County, MD residents were born outside of the United States, which is lower than the national average of 13.5%. In 2019, the percentage of foreign-born citizens in Washington County, MD, was 5.19%, meaning that the rate has decreased.

Age

- In 2020, the median age of all people in Washington County, MD, was 40.7. Native-born citizens, with a median age of 40, were generally younger than foreign-born citizens, with a median age of 44. But people in Washington County, MD, are getting older. In 2019, the average age of all Washington County, MD residents was 41.

[64] Rural Health Information Hub
[65] Ibid.
[66] Ibid.
[67] Data USA

Income and Poverty

- Households in Washington County, MD, have a median annual income of $63,510, less than the median annual income of $64,994 across the entire United States. This is in comparison to a median income of $60,860 in 2019, representing a 4.35% yearly growth.
- 12% of the population for whom poverty status is determined in Washington County, MD (17.1k out of 142k people) live below the poverty line, which is lower than the national average of 12.8%. The largest demographic living in poverty are Females 25 - 34, females 45 - 54, and females 18 - 24.
- In 2020, full-time male employees in Maryland made 1.25 times more than female employees.
- The most common racial or ethnic group living below the poverty line in Washington County, MD, is White, followed by Black and Two Or More.

Employment

- From 2019 to 2020, employment in Washington County, MD, grew at a rate of 0.499%, from 68.5k employees to 68.9k employees.
- The most common employment sectors for those who live in Washington County, MD, are Health Care & Social Assistance, Retail Trade, and Construction.

Education

- In 2020, universities in Washington County, MD, awarded 801 degrees. Washington County, MD's student population is skewed towards women, with 1,172 male and 2,363 female students.
- Most students graduating from Universities in Washington County, MD are White (580 and 73.3%), followed by Black or African American (97 and 12.3%), Hispanic or Latino (51 and 6.45%), and Asian (25 and 3.16%).
- The largest universities in Washington County, MD, by the number of degrees awarded, are Hagerstown Community College (767 and 95.8%) and Award Beauty School (34 and 4.24%).
- The most popular majors in Washington County, MD are Liberal Arts & Sciences (181 and 22.6%), Registered Nursing (79 and 9.86%), and Other Liberal Arts & Sciences, General Studies, & Humanities (75 and 9.36%).
- In 2020 the most common race/ethnicity group awarded degrees at institutions in Washington County, MD, was White students. These 580 degrees mean that there were 5.98 times more degrees awarded to White students than the next closest race/ethnicity group, Black or African American, with 97 degrees awarded.

Health

- Per capita, personal health care spending in Maryland was $8,602 in 2014. This is a 4.27% increase from the previous year ($8,250).

- On average, primary care physicians in Washington County, MD, see 1,776 patients yearly, representing a 0.948% decrease from the previous year (1,793 patients). Compare this to dentists who see 1,624 patients per year and mental health providers who see 397 patients yearly.

Health Risks

- 14.5% of Washington County residents have diabetes.
- 36.9% of Washington County residents are obese.
- 19.5% of Washington County residents smoke.

Health Overview [68]

- Overall, 7% of Maryland's population under age 65 did not have health insurance in 2021.
- In 2021, the population ratio to primary-care physicians in Maryland was 1,130:1.
- In 2021, the number of hospital discharges for ambulatory-care-sensitive conditions per 100,000 Medicare enrollees was 4,134.

Challenges in Maryland [69]

- High racial disparity in high school graduation rates
- High violent crime rate
- High incidence of chlamydia

Strengths in Maryland [70]

- Low prevalence of excessive drinking
- Low prevalence of frequent physical distress
- Low prevalence of high-risk HIV behaviors

Highlights in Maryland [71]

- Suicide increased 19% from 9.1 to 10.8 deaths per 100,000 population between 2015 and 2019
- Air pollution decreased 19% from 8.3 to 6.7 micrograms of fine particulate per cubic meter between 2015-2017 and 2018-2020
- Multiple chronic conditions decreased 17% from 9.2% to 7.6% of adults between 2018 and 2020

[68] County Health Rankings & Roadmaps
[69] America's Health Rankings
[70] Ibid
[71] Ibid

County Health Rankings [72]

Health is influenced by every aspect of how and where we live. Access to secure and affordable housing, safe neighborhoods, good-paying jobs, and quality early childhood education are important factors that can put people on a path to a healthier life. But access to these opportunities often looks different based on where you live, your race, or the circumstances into which you were born. Data show persistent barriers to opportunity for people with lower incomes and communities of color across the United States. Patterned differences in various health factors emerge from unfair policies and practices at many levels and over many decades.

Medical education programs anchored in communities have great potential to address the present and future needs of physicians who provide care to the region. Maintaining strong ties to the community improves clinical outcomes. Strong community partnerships through medical education will become increasingly critical as hospitals become responsible for health outcomes.

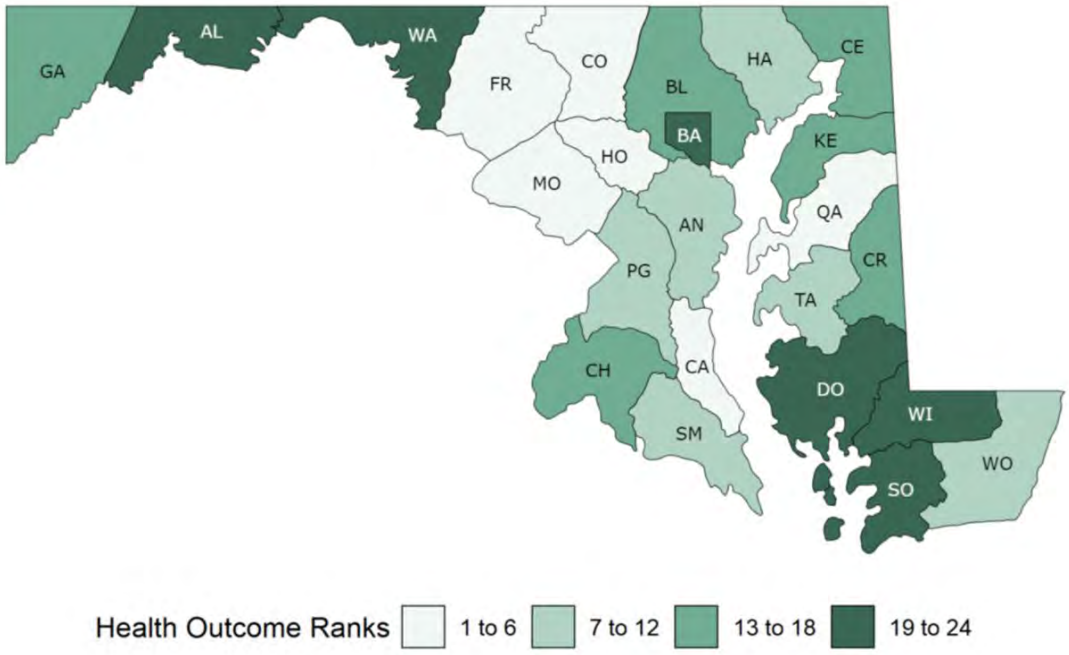
The below table shows the health rankings of Washington County.

Table 20: County Health Rankings in Washington County

Washington County	2022 Ranking (of 23 Counties)
Health Outcomes	20
Length of Life	20
Quality of Life	19
Health Factors	16
Health Behaviors	16
Clinical Care	17
Social and Economic Factors	16
Physical Environment	10

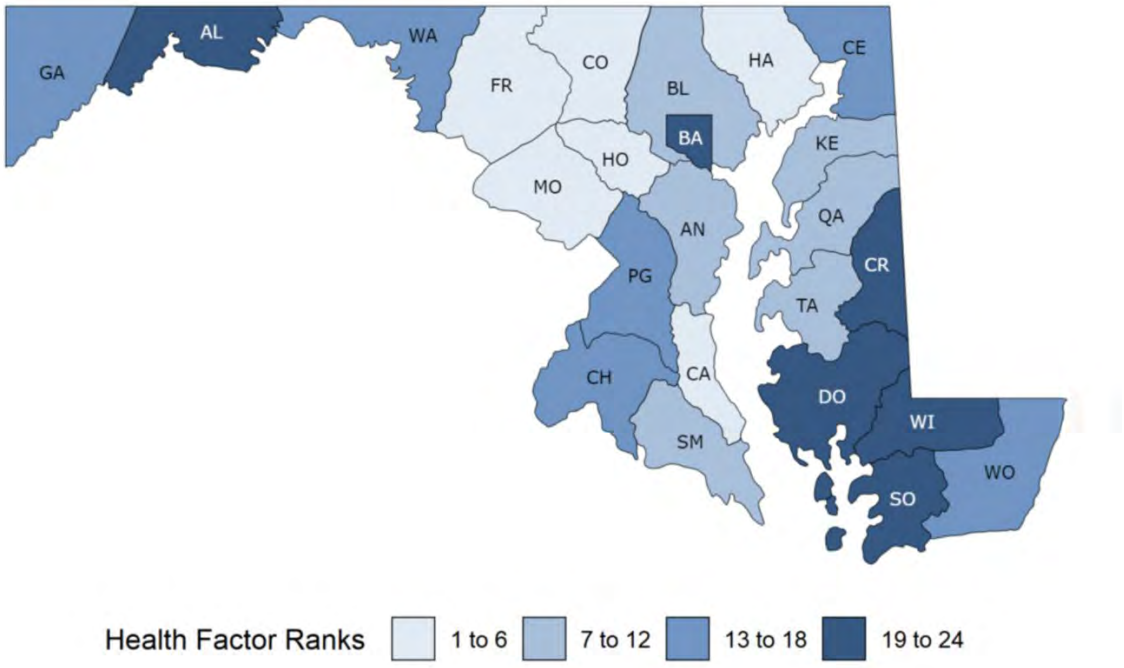
[72] County Health Rankings & Roadmaps

Map 21: 2022 Health Outcomes – Maryland



Source: County Health Rankings & Roadmaps

Map 22: 2022 Health Outcomes – Maryland



Source: County Health Rankings & Roadmaps

Appendix G: Clinical Landscape in Maryland

Table 23 lists the hospitals and medical centers below, totaling more than 10,365 beds in Maryland. These sites are available for opportunities for students to obtain clerkships as well as residency training. Clinical partnership opportunities exist at FQHCs, physician offices, community centers, and clinics.

Table 23: Non-Federal, Short-Term, Acute-Care Hospitals

Hospital Name	City	Staff Beds	Total discharges	Patient Days
Adventist HealthCare Fort Washington Medical Center	Fort Washington	28	1,485	6,394
Adventist HealthCare Shady Grove Medical Center	Rockville	360	19,857	105,756
Adventist HealthCare White Oak Medical Center	Silver Springs	178	11,696	56,612
Anne Arundel Medical Center	Annapolis	379	23,011	103,666
Ascension Saint Agnes Hospital	Baltimore	271	10,769	55,080
Atlantic General Hospital	Berlin	62	2,582	11,219
Calvert Health Medical Center	Prince Frederick	70	5,233	20,506
Carroll Hospital	Westminster	161	7,997	40,019
Christiana Care Union Hospital	Elkton	96	4,419	19,629
Frederick Memorial Hospital	Frederick	284	14,331	73,100
Garrett Regional Medical Center	Oakland	36	1,056	5,224
Grace Medical Center	Baltimore	69	1,757	10,708
Greater Baltimore Medical Center	Baltimore	296	19,937	75,983
Holy Cross Germantown Hospital	Germantown	78	5,039	22,132
Holy Cross Hospital	Silver Spring	423	23,380	129,031
Howard County General Hospital	Columbia	225	13,792	67,993
Johns Hopkins Bayview Medical Center	Baltimore	422	16,976	110,247
Johns Hopkins Suburban Hospital	Bethesda	228	11,485	56,763
Levindale Hebrew Geriatric Center and Hospital	Baltimore	330	1,104	35,124
Luminis Health Doctors Community Medical Center	Lanham	206	10,213	52,591
MedStar Franklin Square Medical Center	Baltimore	338	17,828	87,396
Medstar Good Samaritan Hospital	Baltimore	214	7,753	33,750

Hospital Name	City	Staff Beds	Total discharges	Patient Days
MedStar Harbor Hospital	Baltimore	131	6,666	36,298
MedStar Montgomery Medical Center	Olney	104	5,471	27,685
MedStar Saint Mary's Hospital	Leonardtown	93	6,648	26,124
MedStar Southern Maryland Hospital	Clinton	178	9,846	48,345
MedStar Union Memorial Hospital	Baltimore	185	9,361	41,502
Mercy Medical Center	Baltimore	238	11,791	52,359
Meritus Medical Center	Hagerstown	274	14,366	67,869
Northwest Hospital	Randallstown	229	8,029	48,228
Sinai Hospital	Baltimore	426	25,241	123,658
The Johns Hopkins Hospital	Baltimore	1,019	37,955	298,352
TidalHealth Peninsula Regional	Salisbury	225	11,592	66,998
UM Capital Region Medical Center	Largo	269	14,145	77,725
UM Harford Memorial Hospital	Havre de Grace	82	4,423	21,608
UM Laurel Medical Center	Laurel	124	3,539	18,517
UM Upper Chesapeake Medical Center	Bel Air	161	12,415	53,232
University of Maryland Baltimore Washington Medical Center	Glen Burnie	285	18,896	84,510
University of Maryland Charles Regional Medical Center	La Plata	93	6,256	26,958
University of Maryland Medical Center	Baltimore	846	23,939	214,046
University of Maryland Medical Center Midtown Campus	Baltimore	180	5,120	36,914
The University of Maryland Rehabilitation and Orthopaedic Institute	Baltimore	136	2,065	29,964
University of Maryland Saint Joseph Medical Center	Towson	239	13,310	59,791
University of Maryland Shore Medical Center at Chestertown	Chestertown	12	580	2,063
University of Maryland Shore Medical Center at Easton	Easton	148	6,647	31,309
UPMC Western Maryland	Cumberland	204	10,122	49,450
T O T A L		10,635	500,123	2,722,428

Source: American Hospital Directory

Table 24: Federally Qualified Health Centers and Look-Alikes in Maryland[73]

Name of FQHCs and Look-Alikes	County
Tri-State Community Health Center	Allegany County
Tri-State Women's Health Center	Allegany County
Mountain Laurel Medical Center	Allegany County
Odenton Health Center	Anne Arundel County
Chase Brexton Health Care at Anne Arundel County	Anne Arundel County
Chase Brexton Health Services, Inc. - Glen Burnie Center	Anne Arundel County
Owensville Primary Care, Inc.	Anne Arundel County
OPC Shady Side V1	Anne Arundel County
Healthcare for the Homeless, Inc.	Baltimore City
Health Care for the Homeless	Baltimore City
HCH Mobile Van	Baltimore City
Convalescent Care Program	Baltimore City
Health Care for the Homeless, West Baltimore	Baltimore City
Total Health Care, Inc.	Baltimore City
Saratoga Health Center	Baltimore City
Division Health Center	Baltimore City
Kirk Health Center	Baltimore City
Men's Health Center	Baltimore City
Mondawmin Mall Health Center	Baltimore City
Total Health Care at Open Gates Health Center	Baltimore City
Family Health Centers of Baltimore	Baltimore City
Westside Health Center	Baltimore City
Family Health Centers of Baltimore, Inc.	Baltimore City
FHCB - Brooklyn	Baltimore City
Chase Brexton Health Services, Inc	Baltimore City
Chase Brexton Health Services, Inc. - Mt. Vernon Center	Baltimore City
Baltimore Medical System, Inc.	Baltimore City
Tench Tilghman K-8 School	Baltimore City
Collington Square K-8 School	Baltimore City
BMS at St. Agnes	Baltimore City
Belair Edison Family Health Center	Baltimore City
Vanguard Collegiate Middle School	Baltimore City
Highlandtown Healthy Living Center	Baltimore City
Harford Heights Schools	Baltimore City

[73] Health Resources & Services Administration

Name of FQHCs and Look-Alikes	County
Patterson Senior High School	Baltimore City
Paul Laurence Dunbar High School	Baltimore City
Mergenthaler Vocational-Technical High School (Mervo)	Baltimore City
BMS Pine Heights Health Center	Baltimore City
Absolute Care Inc.	Baltimore City
Forest Park High School	Baltimore City
East Baltimore Medical Center	Baltimore City
Park West Health System inc.	Baltimore City
Park West Men & Family Health Center	Baltimore City
Park West Medical Center - Belvedere	Baltimore City
Park West Medical Center – Plaza Site	Baltimore City
Baltimore County Eastern Family Resource Center	Baltimore County
Chase Brexton Health Services, Inc. - Randallstown Center	Baltimore County
BMS at Rosedale	Baltimore County
Choptank Community Health Center	Caroline County
Federalsburg Medical and Dental Center	Caroline County
Goldsboro Medical and Dental Center	Caroline County
North Caroline High School	Caroline County
Colonel Richardson Middle School	Caroline County
Migrant Camps on Upper Eastern Shore (15 Camps)	Caroline County
Federalsburg Elementary School	Caroline County
Lockerman Middle School	Caroline County
Ridgely Elementary School	Caroline County
Col. Richardson High School	Caroline County
Denton Elementary School	Caroline County
Preston Elementary School	Caroline County
Women, Infants, and Children (WIC)	Caroline County
Denton Medical Center	Caroline County
Greensboro Elementary School	Caroline County
Choptank Mobile Van #1	Caroline County
West Cecil Health Center	Cecil County
Greater Baden Medical Services at La Plata	Charles County
Fassett-Magee Health Center/Cambridge Dental Center	Dorchester County
St. Clair Head Start Center	Dorchester County
Hurlock Head Start Center	Dorchester County
Women, Infants, and Children (WIC)	Dorchester County
City of Frederick	Frederick County
Hillcrest Elementary School - School-Based Health Center	Frederick County

Name of FQHCs and Look-Alikes	County
The City of Frederick Housing and Human Services/FCAA	Frederick County
Western Maryland Health Care Corporation	Garrett County
Mountain Laurel Medical Center	Garrett County
Mountain Laurel Medical Center Grantsville	Garrett County
Mountain Laurel Medical Center Support Staff Office	Garrett County
Beacon Health Center	Harford County
West Cecil Health Center, Inc.	Harford County
Chase Brexton Health Services, Inc. - Columbia Center	Howard County
Chase Brexton Health Services, Inc. at Way Station, Inc.	Howard County
Howard County Health Department - WIC - Dental	Howard County
Angelica Nursery Migrant Camp	Kent County
Chestertown Health Center	Kent County
Rock Hall Elementary School	Kent County
MOBILE MEDICAL CARE, INC.	Montgomery County
MobileMed Long Branch Community Center Van	Montgomery County
MobileMed Rockville Clinic	Montgomery County
Mobile Med Germantown Clinic	Montgomery County
Mobile Med Aspen Hill Clinic	Montgomery County
Mobile Med East Montgomery Service Center	Montgomery County
Mobile Med Gaithersburg/Ascension House Van	Montgomery County
Mary's Center - Silver Spring MD	Montgomery County
Community Clinic Inc.	Montgomery County
CCI-Takoma Park	Montgomery County
CCI Gaithersburg Dental	Montgomery County
CCI-Silver Spring	Montgomery County
CCI-Rockville	Montgomery County
CCI-Gaithersburg	Montgomery County
CCI-Wheaton	Montgomery County
Community Clinic, Inc	Montgomery County
Northwestern High School	Prince George's County
La Clinica del Pueblo - Hyattsville Site	Prince George's County
Hyattsville Middle School	Prince George's County
College Park	Prince George's County
Greater Baden Medical Service Inc.	Prince George's County
Greater Baden Medical Services at Capital Heights	Prince George's County
Greater Baden Medical Services at Brandywine	Prince George's County
Greater Baden Medical Services at Capitol Heights II	Prince George's County
Greater Baden Medical Services at Oxon Hill	Prince George's County

Name of FQHCs and Look-Alikes	County
Absolute CARE of MD2, LLC	Prince George's County
FMCS-Seat Pleasant	Prince George's County
Mary's Center - Adelphi MD	Prince George's County
Mary's Center Dental Bus	Prince George's County
Cool Spring Elementary School	Prince George's County
CCI-Greenbelt	Prince George's County
CCI-Greenway	Prince George's County
SEW FRIEL MIGRANT CAMP	Queen Anne's County
Church Hill Elementary School	Queen Anne's County
Sudlersville Elementary School	Queen Anne's County
Sudlersville Middle School	Queen Anne's County
Three Lower Counties Community Services Inc.	Somerset County
TLC - Princess Anne Dental	Somerset County
CHC - SBHC @ Washington High School	Somerset County
Greater Baden Medical Services at Leonardtown	St. Mary's County
Bay Hundred Medical and Dental Center	Talbot County
Easton Elementary School - Moton and Dobson Buildings	Talbot County
Easton Middle School	Talbot County
St. Michaels Middle/High School	Talbot County
St. Michaels Elementary	Talbot County
Easton High School	Talbot County
Women, Infants, and Children (WIC) Talbot County	Talbot County
Choptank Community Health Easton Pediatrics	Talbot County
Tilghman Elementary School	Talbot County
White Marsh Elementary School	Talbot County
Chase Brexton Health Services, Inc. - Easton Center	Talbot County
Walnut Street Community Health Center, Inc.	Washington County
WSCHC Healthy Smiles in Motion	Washington County
Walnut Street Community Health Center, Inc. D/B/A Family Healthcare of Hagerstown	Washington County
Healthy Smiles II	Washington County
Family Healthcare of Hagerstown at Wells House	Washington County
Tri-State Community Health Center	Washington County
Three Lower Counties Community Services, Inc.	Wicomico County
Chesapeake Health Care Pediatrics	Wicomico County
Peninsula Regional Medical Center	Wicomico County
TLC Salisbury	Wicomico County
TLC @ Riverside Drive	Wicomico County

Name of FQHCs and Look-Alikes	County
Chesapeake Health Care - Sweetbay	Wicomico County
TLC Internal Medicine @ Woodbrooke	Wicomico County
Delmarva Pharmacy	Wicomico County
TLC - Corporate Office	Wicomico County
Eastern Shore OB/GYN, a Division of Chesapeake Health Care	Wicomico County
CHC - Salisbury Dental	Wicomico County
CHC - SBHC - BRES	Wicomico County
CHC - Berlin 9958	Worcester County
CHC - SBHC - POC	Worcester County

*Some facilities have multiple locations in the surrounding area

Source: HRSA

Appendix H: AACOMAS – Profile Applicant and Matriculants

The 2021 AACOMAS Profile: Applicants and Matriculants Report

American Association of Colleges of Osteopathic Medicine Applicant and Matriculant Characteristics

- A total of 27,277 applicants and 8,516 matriculants are represented. These applicants submitted 243,565 individual school applications and the matriculants submitted 88,684 individual school applications.
- The mean number of individual school applications per applicant was 8.94 and per matriculant was 10.36.
- Women represented 54.1% of the applicant pool and 51.9% of the matriculant pool.
- The mean age was 23 for both applicants and matriculants in 2020.
- For the single race/ethnicity category, the percentage of under-represented minorities is 17.0% for applicants and 11.1% for matriculants.

GPA

Applicant's undergraduate GPAs are as follows:

- Non-Science: 3.61
- Science: 3.37
- Total: 3.48

Matriculants' undergraduate GPAs are as follows:

- Non-Science: 3.67
- Science: 3.47
- Total: 3.56

Women had a higher total undergraduate mean GPA compared to men, 3.48 compared to 3.44 for applicants and 3.56 to 3.51 for matriculants.

Nonresident alien applicants and matriculants' total undergraduate mean GPA was 3.55 and 3.66, respectively—the highest compared to all other single category races/ethnicities.

MCAT Scores

Applicants' mean scores for the MCAT are as follows:

- Psychological, social, and biological foundations of behavior: 126.63
- Biological and biochemical foundations of living systems: 125.87
- Chemical and physical foundations of biological systems: 125.43

- Critical analysis and reasoning skills: 124.86
- Total for all sections: 502.80

Matriculants' mean scores for the MCAT are as follows:

- Psychological, social, and biological foundations of behavior: 127.13
- Biological and biochemical foundations of living systems: 126.42
- Chemical and physical foundations of biological systems: 125.91
- Critical analysis and reasoning skills: 125.18
- Total for all sections: 504.64

Health Resources and Services Administration (HRSA) Indicators:

- A total of 7,780 (28.5%) applicants graduated from a high school where many students are eligible for free or reduced lunch. Two other HRSA indicators—living in a Health Professional Shortage Area (HPSA) and economically disadvantaged—are reported by 5,599 (20.5%) and 5,232 (19.2%) applicants.
- A total of 2,158 (25.3%) matriculants graduated from a high school where many are eligible for free or reduced lunch. Living in an HPSA and being economically disadvantaged are reported by 1,511 (17.7%) and 1,298 (15.2%).
- Applicants living in a large town totaled 7,225 (26.5%). Nearly five percent of applicants—1,339—were from an isolated rural area.
- Matriculants living in a large town totaled 2,443 (28.7%). Nearly five percent of matriculants—416—were from an isolated rural area.

Appendix I: Rurally Located Medical Schools in the United States

The table below lists M.D. or D.O. schools located rurally in the U.S.

School or Institution	Accreditation	Date of Accreditation	State	HPSA or MUA/MUP	Medical school rural track program?	Rural residency track	Medical school track Name
University of Pikeville Kentucky College of Osteopathic Medicine	COCA	2001	Kentucky	MUA (Pike Service Area 1978)	No	No	
Central Michigan University College of Medicine	LCME	2012	Michigan	HPSA for primary care	No	No	
AT Still University Kirksville College of Osteopathic Medicine	COCA	1903	Missouri	HPSA for primary care	No	No	
Geisel School of Medicine - Dartmouth College	LCME	1942	New Hampshire	No	Yes	No	Rural Health Scholars
Ohio University Heritage College of Osteopathic Medicine	COCA	1979	Ohio	No	Yes	No	Rural and Urban Scholars Pathways Program
University of South Dakota Sanford School of Medicine	LCME	1942	South Dakota	No	Yes	Yes, Pierre	Frontier And Rural Medicine (FARM) Program
Lincoln Memorial University-DeBusk College of Osteopathic Medicine	COCA	2011	Tennessee	HPSA for primary care	No	No	

School or Institution	Accreditation	Date of Accreditation	State	HPSA or MUA/MUP	Medical school rural track program?	Rural residency track	Medical school track Name
University of Texas Medical Branch Galveston	LCME	1942	Texas	No	Yes	No	Rural Health Care Track (RHCT)
West Virginia School of Osteopathic Medicine	COCA	1974	West Virginia	HPSA for primary care	Yes	No	Rural Health Initiative Program

Appendix J: Applicants to Osteopathic Medical Schools

The table below shows the number of applications for the 2021 academic year for each osteopathic medical school. In 2021, not one school had fewer than 1,000 applicants.[74]

Table 25: 2021-2022 Applicants to Osteopathic Medical Schools

Colleges of Osteopathic Medicine/Schools of Osteopathic Medicine	Total
ACOM	5,871
ARCOM	3,463
ATSU-KCOM	5,323
ATSU-SOMA	7,902
AZCOM	7,440
BCOM	4,624
CCOM	8,569
CHSU-COM	3,939
CUSOM	4,823
DMU-COM	4,697
ICOM	3,521
KCU-Kansas	5,981
LECOM	11,819
LECOM Bradenton	9,052
LMU-DCOM	7,067
LUCOM	4,364
MSUCOM	8,161
MU-COM	5,700
Noorda COM	1,283
NSU-KPCOM	8,212
NYITCOM Long Island	9,925
OSU-COM	4,707
OU-HCOM	5,692
PCOM & S. Georgia	9,960
PCOM Georgia	4,411
PNWU-COM	5,194
Rowan SOM	6,931
RVUCOM Colorado/Utah	3,924
Touro COM-NY	7,943
TUCOM-CA	6,045
TUNCOM	4,231
UIWSOM	5,322
UNE COM	4,046
UP-KYCOM	4,512
VCOM-Auburn	3,961

[74] American Association of Colleges of Osteopathic Medicine (AACOM): 2021 AACOM Report on Applicant Designations

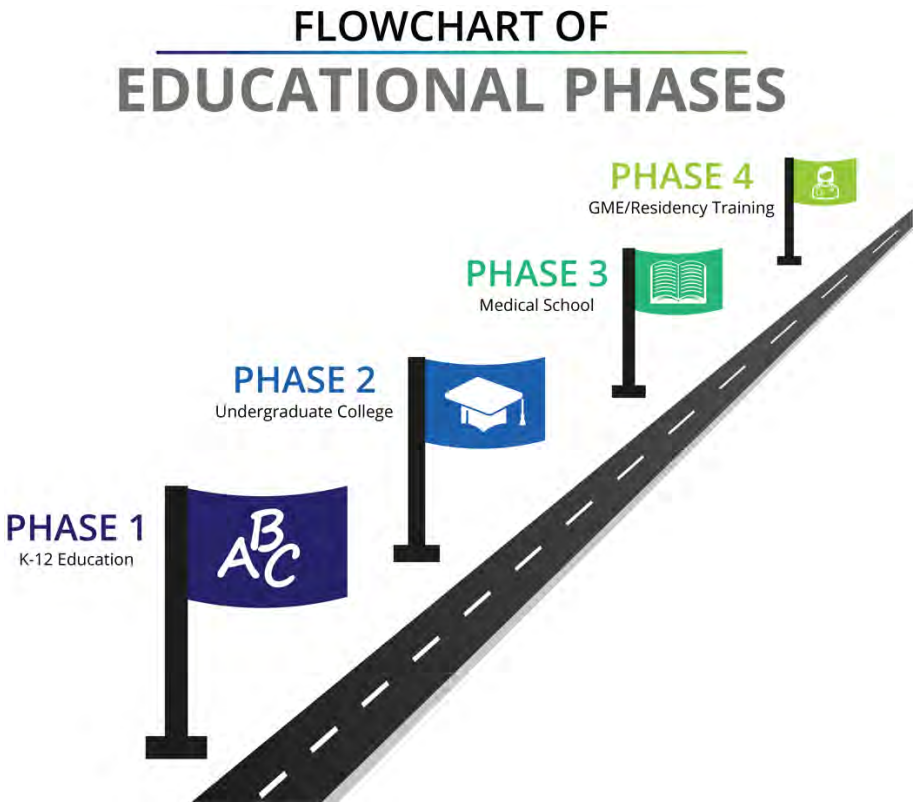
Colleges of Osteopathic Medicine/Schools of Osteopathic Medicine	Total
VCOM-Carolinas	5,092
VCOM-Louisiana	2,667
VCOM-Virginia	6,516
WCUCOM	3,836
Western U/COMP	7,045
Western U/COMP-Northwest	4,536
WVSOM	5,258
Total	**243,565**

Appendix K: Overview of Osteopathic Medicine

Medical Education Overview

The typical path to becoming a physician, both allopathic and osteopathic, is to complete a traditional four-year undergraduate degree, preferably in one of the sciences (i.e., life, social, physical, pre-med, etc.). Due to the nature of a focused undergraduate degree in the sciences, this degree is designated as undergraduate medical education (UME) for those entering the medical field. The student must then apply and be accepted to medical school. The student then attends the first two years of medical school in a classroom setting. Years three and four of medical school are typically spent conducting clinical clerkships outside the classroom in settings such as hospitals, clinics, health centers, etc. Finally, the student must complete GME and a residency program for three to seven years. Residency positions are held by local hospitals, health centers, and/or FQHCs.

Figure 26: Flowchart of Educational Phases of the Medical Education Pipeline



While the basic curriculum of the allopathic and osteopathic colleges is the same, there are some important differences. The basic sciences and hospital training are taught from an osteopathic viewpoint, with a heavy emphasis on anatomy. Osteopathic medicine provides all the benefits of modern medicine, including prescription drugs, surgery, and technology to diagnose disease and evaluate the injury. It also offers the added benefit of hands-on diagnosis and treatment through osteopathic manipulative medicine, which emphasizes helping each person achieve a high level of

wellness by focusing on health promotion and disease prevention.[75] Additional hours are spent learning osteopathic manipulative medicine techniques and focusing on preventive health care and nutrition.

Osteopathic Medical Schools Train Physicians to Meet a Well-Documented Need

Colleges of osteopathic medicine continue to expand to meet the needs of America's physician workforce. This past year, the number of osteopathic physicians in the United States climbed to nearly 135,000, an 80% increase over the past decade.[76] The nation's 134,901 fully licensed active and practicing osteopathic physicians cover the entire scope of modern medicine, bringing a patient-centered, holistic, hands-on approach to diagnosing and treating illness and injury.

Osteopathic physicians can choose any specialty, prescribe drugs, perform surgeries, and practice medicine anywhere in the United States. Osteopathic physicians bring the additional benefits of osteopathic manipulative techniques to diagnose and treat patients. Osteopathic physicians work in partnership with patients to help them achieve a high level of wellness by focusing on health education, injury prevention, and disease prevention.

- Most D.O.s (56.5%) go into primary care, with 30.0% landing in family medicine, 19.0% in internal medicine, and 7.5% in pediatrics.[77]
- In 2020-2021 the top five non-primary-care specialties for D.O.s were emergency medicine (10.0%), followed by obstetrics and gynecology (5.0%), anesthesiology (4.0%), general surgery (4.0%), and psychiatry (4.0 %).

Even though many new colleges of osteopathic medicine and regional campuses have opened or been approved by the COCA during the past five years, Tripp Umbach believes that the demand for osteopathic physicians will continue to grow faster during the next 20 years than the supply of medical school graduates.

[75] American Association of Colleges of Osteopathic Medicine (AACOM)
[76] American Osteopathic Association: 2020-21-Osteopathic Medical Profession Report
[77] Ibid.

Appendix L: Consultant Qualifications

Since 1990, Tripp Umbach has consulted with more than 100 academic medical centers. Tripp Umbach is an established national leader in providing feasibility studies and business plans for health science universities, academic medical centers, health systems, new and/or expanding medical schools, and communities that wish to develop and expand both undergraduate (UME) and graduate medical education (GME).

Tripp Umbach has conducted in-depth feasibility analyses for a wide variety of institutions and clients throughout the United States and internationally. Clients have included more than 30 new or expanding medical schools (both allopathic and osteopathic); numerous statewide partnerships; statewide and regional business plans for expanding GME; and feasibility studies for establishing physician assistant, physical therapy, pharmacy, optometry, and dental programs.

Tripp Umbach is the leading firm in conducting economic impact studies for health care and higher education institutions, having measured the economic impact of every U.S. medical school and major teaching hospital since 1995.

Tripp Umbach
Turning Ideas Into Action

FitchRatings

16 SEP 2021

Fitch Upgrades Meritus' (MD) Revenue Bonds to 'A'; Outlook Revised to Stable From Positive

Fitch Ratings - Austin - 16 Sep 2021: Fitch Ratings has upgraded the rating on the series 2015 revenue bonds issued by the Maryland Health & Higher Educational Facilities Authority of Maryland on behalf of Meritus Medical Center (Meritus) to 'A' from 'A-'.

In addition, Fitch has also upgraded Meritus' Issuer Default Rating to 'A' from 'A-'.

The Rating Outlook is revised to Stable from Positive.

SECURITY

The bonds are secured by mortgage and gross receipts pledge.

ANALYTICAL CONCLUSION

The upgrade to 'A' reflects Meritus' very strong operating cash flow in fiscal 2021 (ending June 30) and investment portfolio performance that has resulted in a material yoy improvement in Meritus' leverage metrics. The rating also reflects Meritus' robust market share in a state with predictable revenue streams under the GBR reimbursement methodology.

Meritus received an emergency certificate of need in March 2020 for a new 20-bed regional infection containment wing. The project was completed in 120 days and the wing has treated over 1,200 COVID-19 patients to date. Fitch believes that Meritus' capital needs are limited following the construction of the 20-bed unit. Capital expenditures over the medium-term will be focused on outpatient services that will allow the organization to enhance its population health capabilities. Future capital investments should help Meritus to maintain a low total cost of care, providing Meritus with operating cash flow margins that are sufficient enough to both fund routine/strategic capital and improve the balance sheet over time.

While the combination of mid-range revenue defensibility, strong operating performance, and strong financial profile is generally consistent with a suggested 'AA' rating category, the ratings are constrained by vulnerability associated with Meritus' small population and revenue base.

KEY RATING DRIVERS

Revenue Defensibility: 'bbb'

Robust Market Position in a Service Area with Limited Growth.

Meritus' mid-range revenue defensibility is supported by a leading inpatient market share of around 80% and a moderate level of Medicaid and self-pay revenues that accounted for a combined 21.4% of the gross payor mix in fiscal 2021. Meritus has been operating under Maryland's Total Patient Revenue since 2010 and converted to Global Budget Revenue since 2016 established by Maryland's Health Services Cost Review Commission (HSCRC), an independent State agency that regulated hospital charges to be paid by all Maryland payers.

Both models offer participants a fixed revenue stream designed to incentivize institutions to avoid unnecessary utilization and manage care in the most appropriate cost setting. Since 2019, Maryland's health care model has also included the management of patient costs in settings such as ambulatory surgery, specialty physician offices, urgent care, home care and hospice and skilled nursing facilities. Fitch views the Maryland All Payer Model, from which the system derives a significant portion of its net patient revenues, as providing a significant level of stability and predictability, allowing Maryland hospitals to better manage and budget annual expenses.

Operating Risk: 'a'

Very Strong Fiscal 2021 Operating Cash Flow; Limited Capital Needs

Net patient revenue increased 22% from fiscal 2020 to fiscal 2021 as the HSCRC allowed the hospital to increase rates above the 5% corridor to stabilize hospital revenue. Meritus deferred $24.7 million in approved charges in fiscal 2020, of which $16.9 million has since been charged in fiscal 2021. This helped to temporarily increase the organization's operating EBITDA to $99.3 million from $33.3 million in fiscal 2020, even in the midst of an increase in contract labor expense. Historically, HSCRC policy would allow the remaining $7.8 million of the undercharge from fiscal year 2021 to be carried over into next fiscal year in January.

Given the All Payer Model in Maryland, Meritus' management team is very focused on affordability and cost of care, which should help the organization maintain a long-term operating EBITDA margin at or above 9% going forward. Over the near-term, management's efforts towards its efficiency and affordability goals include the growth of its ambulatory pharmacy service line, reduction of denials and limiting supply chain costs. In addition, Meritus is focused on the growth of providers in the clinically integrated network and the improvement of its value-based contracts with commercial payors.

Fitch believes that Meritus' capital expenditure needs are very manageable given the recent completion of the Epic implementation and 20-bed regional infection containment wing in 2020. The new wing should limit Meritus' medium term inpatient related capital needs and allow the organization to focus on strategic and ambulatory services that are typically not as costly as inpatient construction projects. Going forward, capital spending is projected to average around $30 million over the next five fiscal years, with a focus on the growth of Meritus' physician practices and purchasing technology and equipment that allows Meritus to expand the depth and breadth of its services, while reducing patient out-migration.

Financial Profile: 'aa'

Improving Capital-Related Ratios through the Cycle

Meritus' cash-to-adjusted debt, as calculated by Fitch, improved to 138.4% as of fiscal YE 2021 (excluding $57.8 million in Medicare advanced payments) from 101.6% as of fiscal YE 2020 (excluding $66 million in Medicare advance payments). The increase in cash from fiscal 2021 from fiscal 2020 was primarily accomplished through an increase in Meritus' operating EBITDA to $99.3 million combined with $46 million in investment income in 2021.

Looking forward, Fitch believes the system's strategic initiatives focused on keeping care local and becoming a more efficient, higher quality and lower cost of care health system, should allow Meritus to maintain operating EBITDA margins around 9%. Given the expectation of sufficient cash flow generation and balanced capital spending, Meritus' balance sheet should continue to improve. Fitch's forward-looking analysis shows Meritus quickly recovering through a downside stress scenario. Fitch's scenario analysis assumes an economic stress in year one and two followed by a recovery and then growth and stability in years three through five. Fitch's stress case includes an investment portfolio stress in year one of 9%, based on Meritus' actual investment allocation. Even with the stress, Fitch's forward-looking analysis shows cash-to-adjusted debt rebounding to 140% by year four and net adjusted debt-to-adjusted EBITDA remains favorably negative in every year of the stress case, which supports the upgrade of the rating.

Asymmetric Additional Risk Considerations

No asymmetric risk factors were applied in this rating determination.

RATING SENSITIVITIES

Factors that could, individually or collectively, lead to a positive rating action/upgrade:

--Improvement in cash-to-adjusted debt to be at or above 190%.

Factors that could, individually or collectively, lead to a negative rating action/downgrade:

--A sustained deterioration in unrestricted cash and investments related to operating declines or capex spending levels far exceeding current plans that would result in financial profile metrics inconsistent with the rating category;

--A sustained deterioration in operating margins, with operating EBITDA margins that are maintained around 7%.

Best/Worst Case Rating Scenario

International scale credit ratings of Sovereigns, Public Finance and Infrastructure issuers have a best-case rating upgrade scenario (defined as the 99th percentile of rating transitions, measured in a positive direction) of three notches over a three-year rating horizon; and a worst-case rating downgrade scenario (defined as the 99th percentile of rating transitions, measured in a negative direction) of three notches over three years. The complete span of best- and worst-case scenario credit

ratings for all rating categories ranges from 'AAA' to 'D'. Best- and worst-case scenario credit ratings are based on historical performance. For more information about the methodology used to determine sector-specific best- and worst-case scenario credit ratings, visit https://www.fitchratings.com/site/re/10111579.

Meritus Medical Center is a 277-bed hospital located in Hagerstown, MD. Meritus Medical Center is the only member of the obligated group and represented 86% of the consolidated operating revenue of consolidated system in fiscal 2021. Fitch's analysis is based on the consolidated system. In fiscal 2021 (June 30 YE), Meritus had total operating revenues of $480.5 million.

In addition to the sources of information identified in Fitch's applicable criteria specified below, this action was informed by information from Lumesis.

REFERENCES FOR SUBSTANTIALLY MATERIAL SOURCE CITED AS KEY DRIVER OF RATING

The principal sources of information used in the analysis are described in the Applicable Criteria.

ESG Considerations

Unless otherwise disclosed in this section, the highest level of ESG credit relevance is a score of '3'. This means ESG issues are credit-neutral or have only a minimal credit impact on the entity, either due to their nature or the way in which they are being managed by the entity. For more information on Fitch's ESG Relevance Scores, visit www.fitchratings.com/esg

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Rating Actions

ENTITY/DEBT	RATING		RECOVERY	PRIOR
Meritus Health (MD)	LT IDR	A ⊜	Upgrade	A- ⊕
• Meritus Health (MD) /General Revenues/ 1 LT	LT	A ⊜	Upgrade	A- ⊕

RATINGS KEY	OUTLOOK	WATCH
POSITIVE	⊕	⬘
NEGATIVE	⊖	⬙
EVOLVING	◈	◆
STABLE	⊜	

Applicable Criteria

Public Sector, Revenue-Supported Entities Rating Criteria (pub.01 Sep 2021) (including rating assumption sensitivity)

U.S. Not-For-Profit Hospitals and Health Systems Rating Criteria (pub.18 Nov 2020) (including rating assumption sensitivity)

Applicable Models

Numbers in parentheses accompanying applicable model(s) contain hyperlinks to criteria providing description of model(s).

Portfolio Analysis Model (PAM), v1.3.2 (1)

Additional Disclosures

Solicitation Status

Endorsement Status

Maryland Health & Higher Educational Facilities Authority (MD)	EU Endorsed, UK Endorsed

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obtains will vary depending on the nature of the rated security and its issuer, the requirements and practices in the jurisdiction in which the rated security is offered and sold and/or the issuer is located, the availability and nature of relevant public information, access to the management of the issuer and its advisers, the availability of pre-existing third-party verifications such as audit reports, agreed-upon procedures letters, appraisals, actuarial reports, engineering reports, legal opinions and other reports provided by third parties, the availability of independent and competent third- party verification sources with respect to the particular security or in the particular jurisdiction of the issuer, and a variety of other factors. Users of Fitch's ratings and reports should understand that neither an enhanced factual investigation nor any third-party verification can ensure that all of the information Fitch relies on in connection with a rating or a report will be accurate and complete. Ultimately, the issuer and its advisers are responsible for the accuracy of the information they provide to Fitch and to the market in offering documents and other reports. In issuing its ratings and its reports, Fitch must rely on the work of experts, including independent auditors with respect to financial statements and attorneys with respect to legal and tax matters. Further, ratings and forecasts of financial and other information are inherently forward-looking and embody assumptions and predictions about future events that by their nature cannot be verified as facts. As a result, despite any verification of current facts, ratings and forecasts can be affected by future events or conditions that were not anticipated at the time a rating or forecast was issued or affirmed.

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Exhibit – Start Up Summary

Proposed Meritus School of Osteopathic Medicine (Applicant -- Seeking Accreditation)

Fiscal Year of Operation	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**
Accreditation Phase / Step	**Applicant**	**Candidate**	**Pre-Accreditation**	**Cohort 1**	**Cohort 2**	**Cohort 3**	**Cohort 4**
Proposed Class Size				180	180	180	180
Cohort Size Limitation / Build-up				50%	75%	100%	100%
Projected Entering Students				90	135	180	180
Total Student Population				90	225	405	585
Estimated Tuition & Fees (per student)				$55,000	$56,100	$57,222	$58,366
Revenues	**$ -**	**$ -**	**$ 200**	**$ 6,661**	**$ 14,782**	**$ 25,704**	**$ 36,504**
Budgeted Expenses	4,612	6,696	11,986	17,520	20,850	25,639	28,027
(Deficit/Surplus)	**$ (4,612)**	**$ (6,696)**	**$ (11,786)**	**$ (10,859)**	**$ (6,068)**	**$ 65**	**$ 8,477**

Exhibit – Sources and Uses

Proposed Meritus School of Osteopathic Medicine (Applicant -- Seeking Accreditation)

MERITUS SCHOOL OF OSTEOPATHIC MEDICINE
Sources and Uses of Funds
July 1, 2022 to June 30, 2028

	Planning & Development Jul 1, 2022 - Jun 30, 2025	1st - 3rd Years College Operations Jul 1, 2025 - Jun 30, 2028	Total
SOURCES			
MMC's Working Capital Loan	23,094	29,666	52,759
Meritus board designated investments	50,000	-	50,000
Tuition, net	-	40,747	40,747
Application/Student Fees	200	4,300	4,500
TOTAL SOURCES	73,294	74,713	148,007
USES			
COCA Escrow deposits	50,000	-	50,000
Employees salaries and benefits	12,700	42,137	54,837
Consultants	9,000	2,500	11,500
Supplies, insurance, utilities and other	1,417	29,423	30,840
Contingency	178	653	830
TOTAL USES	73,294	74,713	148,007

KPMG

MERITUS MEDICAL CENTER, INC.

Consolidated Financial Statements and
Supplementary Financial Information

June 30, 2019 and 2018

(With Independent Auditors' Report Thereon)

MERITUS MEDICAL CENTER, INC.

Table of Contents

KPMG LLP
750 East Pratt Street, 18th Floor
Baltimore, MD 21202

Independent Auditors' Report

The Board of Directors
Meritus Medical Center, Inc.:

We have audited the accompanying consolidated financial statements of Meritus Medical Center, Inc. (Meritus), which comprise the consolidated balance sheets as of June 30, 2019 and 2018, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Meritus Medical Center, Inc. as of June 30, 2019 and 2018, and the results of its operations and changes in net assets and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG

Emphasis of Matter

As discussed in note 2 to the consolidated financial statements, Meritus Medical Center, Inc. adopted Financial Accounting Standards Board Accounting Standards Update (ASU) No. 2014-19, *Revenue from Contracts with Customers (Topic 606)* and ASU No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities* during the year ended June 30, 2019. Our opinion is not modified with respect to this matter.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Schedules 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

Baltimore, Maryland
October 2, 2019

MERITUS MEDICAL CENTER, INC.

Consolidated Balance Sheets

June 30, 2019 and 2018

(Dollars in thousands)

Assets		2019	2018
Current assets:			
Cash and cash equivalents	$	32,040	36,971
Short-term investments		34,770	49,545
Current portion of assets whose use is limited		10,577	10,468
Accounts receivable		43,057	44,008
Supplies		5,783	5,645
Prepaid and other current assets		4,113	4,300
Total current assets		130,340	150,937
Assets whose use is limited		207,404	198,310
Property, plant and equipment, net		244,608	251,910
Equity investments in affiliates		36,658	33,381
Other assets		8,001	3,962
Total assets	$	627,011	638,500
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	18,195	19,485
Accrued salaries, wages and withholdings		13,100	11,062
Accrued compensation benefit		12,418	11,055
Advances from third-party payors		13,650	14,511
Accrued interest payable		5,928	6,038
Current portion of long-term debt		6,644	6,863
Total current liabilities		69,935	69,014
Long-term debt, net of current portion		251,233	257,811
Accrued retirement benefits		6,365	6,542
Other long-term liabilities		6,298	9,617
Total liabilities		333,831	342,984
Net assets:			
Unrestricted		287,159	289,523
Restricted		6,021	5,993
Total net assets		293,180	295,516
Total liabilities and net assets	$	627,011	638,500

See accompanying notes to consolidated financial statements.

MERITUS MEDICAL CENTER, INC.

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2019 and 2018

(Dollars in thousands)

	2019	2018
Unrestricted revenue, gains and other support:		
Net patient service revenue	$ 376,849	379,964
Other revenue	9,612	9,578
Equity earnings in affiliates	4,572	2,862
Net assets released from restriction used for operations	1,045	739
Total revenues	392,078	393,143
Expenses:		
Salaries and wages	160,540	145,611
Employee benefits	36,111	34,652
Professional fees	15,904	15,024
Supplies and other	153,908	153,335
Interest	11,449	11,719
Depreciation and amortization	24,975	21,135
Total expenses	402,887	381,476
Operating (losses) income	(10,809)	11,667
Nonoperating gains (losses), net:		
Investment returns, net	8,636	8,030
Other, net	(148)	(517)
Income tax expense	(59)	(445)
(Deficit) excess of revenues over expenses	$ (2,380)	18,735

(Continued)

MERITUS MEDICAL CENTER, INC.

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2019 and 2018

(Dollars in thousands)

	2019	2018
Unrestricted net assets:		
(Deficit) excess of revenues over expenses	$ (2,380)	18,735
Other	16	633
(Decrease) increase in unrestricted net assets	(2,364)	19,368
Restricted net assets:		
Contributions	1,098	886
Other	(25)	42
Net assets released from restriction for operations	(1,045)	(739)
Increase in restricted net assets	28	189
(Decrease) increase in net assets	(2,336)	19,557
Net assets:		
Beginning of year	295,516	275,959
End of year	$ 293,180	295,516

See accompanying notes to the consolidated financial statements.

MERITUS MEDICAL CENTER, INC.

Consolidated Statements of Cash Flows

Years ended June 30, 2019 and 2018

(Dollars in thousands)

	2019	2018
Cash flows from operating activities:		
(Decrease) increase in net assets	$ (2,336)	19,557
Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	24,975	21,135
Net realized and unrealized gains on investments	(6,488)	(7,021)
(Gain) loss on disposal of assets	(1,181)	23
Equity earnings in affiliates	(4,572)	(2,862)
Restricted contributions and other	(1,089)	(1,561)
Changes in assets and liabilities:		
Accounts receivable	952	(2,099)
Supplies, prepaid, and other current assets	49	(614)
Other assets	(4,039)	1,332
Accounts payable, accrued expenses and long-term liabilities	(4,609)	(2,802)
Accrued salaries, wages and withholdings	2,038	1,218
Accrued compensation benefit	1,363	559
Advances from third-party payors	(861)	5,317
Interest payable	(110)	(106)
Accrued retirement benefits	(177)	336
Net cash provided by operating activities	3,915	32,412
Cash flows from investing activities:		
Purchase of property, plant and equipment	(17,737)	(35,243)
Proceeds from the disposal of assets	1,245	84
Purchases of alternative investments	(425)	(8,000)
(Purchases)/sales of restricted cash, short-term investments, and assets whose use is limited, net	12,485	(2,538)
Equity contributions to affiliates, net	1,295	5,157
Net cash used in investing activities	(3,137)	(40,540)
Cash flows from financing activities:		
Payments on long-term debt and capital leases	(6,798)	(6,606)
Restricted contributions and other	1,089	1,561
Net cash used in financing activities	(5,709)	(5,045)
Net decrease in cash and cash equivalents	(4,931)	(13,173)
Cash and cash equivalents:		
Beginning of year	36,971	50,144
End of year	$ 32,040	36,971
Supplemental disclosure of cash flow information:		
Cash paid for interest	$ 11,449	11,719
Cash paid for income taxes	$ 113	162

See accompanying notes to consolidated financial statements.

(1) Description of Organization

Organization

Meritus Medical Center, Inc. (the Hospital or the Company) is the parent corporation of the Meritus Healthcare Foundation, Inc. (the Foundation), the Meritus Insurance Company, Ltd. (MIC), Meritus Health ACO, LLC (MACO) and Meritus Holdings, LLC (Holdings), which owns Meritus Enterprises (MEI). These entities are collectively referred to as "Meritus".

The Hospital is a not-for-profit acute care hospital located in Hagerstown, Maryland and serves the residents of western Maryland, southern Pennsylvania, and the panhandle of West Virginia. The Hospital currently offers acute general hospital inpatient services, including adult medical/surgical care, obstetrics and newborn care, including a family birthing center, cardiac catheterizations, comprehensive inpatient rehabilitation, radiology and diagnostic services, inpatient and outpatient mental health services, a regional Level III Trauma Center, an intensive care unit, an intermediate care unit, and a pediatric unit. The Hospital also manages gifts, donations or bequests given for the benefit of Meritus and owns real estate properties for rental to medical provider entities and development opportunities.

The Foundation is a not-for-profit corporation whose purpose is to raise philanthropic support for the capital and endowment campaigns of the Hospital. The Foundation also raises money for the Hospital's medical programs, healthcare objectives, scientific research, educational programs, and related community activities. Resources for the Foundation's activities are primarily provided by donors.

MIC is a Cayman Island captive insurance company, wholly owned by the Hospital that provides primary limits of insurance to Meritus for professional liability, employed physicians professional liability, comprehensive general liability, deductible, and stop-loss coverage for health insurance.

As of June 30, 2019, MEI a for-profit corporation, held ownership interests in the following joint venture:

- Diagnostic Imaging Services, LLC (DIS), an outpatient imaging services provider

As of June 30, 2019, Holdings a nonprofit corporation, held ownership interests in the following joint ventures:

- General Surgery Real Estate, LLC (GSRE), a real estate holding company
- GI Real Estate Company, LLC (GI REC), a real estate holding company

MEI also owns and operates Equipped for Life, a durable medical equipment company (EFL).

MACO is an Accountable Care Organization (ACO), wholly owned by the Hospital. MACO participates in the following CMS programs:

- Medicare Shared Savings Plan ("MSSP"), effective January 1, 2017
- Maryland Primary Care Program ("MDPCP"), as an approved Care Transformation Organization for Washington County, MD, effective January 1, 2019

(Continued)

(2) Summary of Significant Accounting Policies

(a) Principles of Consolidation

The Company's consolidated financial statements include the subsidiaries in which the Company has 50% or more voting interests or when the Company is deemed to have control. Significant intercompany accounts and transactions have been eliminated in consolidation. The accompanying consolidated financial statements include the accounts of the Hospital, Holdings, MEI, the Foundation, MACO, and MIC. MEI owned a 100% interest in Robinwood Surgery Center, LLC, at June 30, 2017, the Company dissolved in January 2018. All material inter-company balances and transactions have been eliminated in consolidation.

(b) Use of Estimates

The preparation of consolidated financial statements, in conformity with accounting principles generally accepted in the United States of America, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Accordingly, actual results could differ from those estimates.

(c) Cash and Cash Equivalents

Cash and cash equivalents consist of short-term, highly liquid investments that are readily convertible to cash and have original maturities of three months or less. Cash and cash equivalents are carried at cost which approximates fair value.

(d) Patient Accounts Receivable/Allowance for Doubtful Accounts

Patient accounts receivable result from the healthcare services provided by Meritus. Management previously recorded an allowance for doubtful accounts against accounts receivable until the adoption of Accounting Standards Codification (ASC) 606, Revenue Recognition, in the current year ended June 30, 2019 as further disclosed in Footnote 2(M).

(e) Assets Whose Use is Limited

Assets whose use is limited include assets set aside by the Board of Directors for specific purposes, for supplemental retirement benefit investments, to fulfill donor purposes, assets held by trustees under bond indenture agreement, and funds designated for insurance purposes. Amounts required to meet current liabilities are shown as current assets in the consolidated balance sheets.

(Continued)

(f) Investments and Investment Income

Investments in equity securities (i.e., investments that have readily determinable fair values and are not accounted for by the equity method) and all investments in debt securities are reported at fair value on the consolidated balance sheets. Institutional funds are recorded at their readily determinable fair values (RDFV). All securities with the exception of alternative investments are reported at fair value. Alternative investments are recorded under the equity method of accounting.

A significant portion of the Meritus' investments are held in an investment portfolio maintained for the benefit of Meritus and its affiliates and its subsidiaries. Investments are classified as trading securities except for certain investments, which are limited or restricted as to use or do not have the liquidity to qualify as trading securities and are classified as investments available for sale.

Investment income and realized gains are recorded as nonoperating revenue. Unrealized gains and losses on trading securities are recorded as nonoperating revenue. Unrealized gains and losses on available for sale investments are included in other changes in net assets. Investment income and realized gains and losses on assets restricted by donors for specific purposes or endowment are included in restricted net assets.

Investment income, which includes interest and dividends, on proceeds of borrowings that are held by a trustee are reported as other revenue. Other investment income, which includes interest, dividends and realized and unrealized gains and losses on assets limited as to use by Board of Directors and funds designated for insurance purposes are recorded as nonoperating gains (losses), net, unless the income or loss is restricted by donor or law.

Meritus' investments are managed by investment managers. Investment securities, in general, are exposed to various risks, such as interest rate, credit and overall market volatility. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near term and that such change could materially affect the amounts reported in the consolidated financial statements.

(g) Supplies

Supplies for the Hospital are carried at cost on a weighted average basis.

(Continued)

(Dollars in thousands)

(h) Property, Plant and Equipment

Property, plant and equipment acquisitions are recorded at cost. Those assets acquired by gift are carried at amounts established as fair value at the time of acquisition. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Equipment under capital lease is amortized by the straight-line method over the shorter of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the consolidated financial statements. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. No interest was capitalized during the years ended June 30, 2019 and 2018. Leasehold improvements are amortized over the lesser of the useful life or the lease life. Durable medical equipment held for resale is included in supplies. The remainder of durable medical equipment is rented to patients and is included in property, plant and equipment. Assets are retired or disposed of at book value and related gains or losses are recorded for assets sold. Useful lives range as follows:

Land improvements	5–25 years
Buildings	10–40 years
Equipment	3–20 years
Leasehold improvements	The lesser of the useful life or lease term

Gifts of long-lived assets such as land, buildings, or equipment are reported as other changes in unrestricted net assets unless explicit donor stipulations specify how the donated assets must be used. When applicable, gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long-lived assets must be maintained, expirations of donor restrictions, occur when the donated or acquired long-lived assets are placed into service.

Meritus continually evaluates whether events and circumstances have occurred that indicate the remaining estimated useful life of long-lived assets is appropriate, or whether the remaining balance may not be recoverable. When factors indicate that long-lived assets should be evaluated for possible impairment, Meritus uses an estimate of the related undiscounted operating income over the remaining life of the long lived asset in measuring whether the long-lived asset is recoverable.

The impairment loss on these assets is measured as the excess of the carrying amount of the asset over its fair value. Fair value is based upon market prices, where available, or discounted cash flows. Management believes that no revision to the remaining useful lives is required and there were no impairment of long-lived assets during the years ended June 30, 2019 and 2018.

(i) Deferred Financing Costs

Financing costs incurred in issuing debt have been capitalized and are being amortized over the life of the debt using the effective interest method.

(Continued)

(j) Compensated Absences

Meritus records a liability for amounts due to employees for future absences which are attributable to services performed in the current and prior periods. This liability is included in accrued salaries, wages and withholdings on the consolidated balance sheets.

(k) Restricted Net Assets

Restricted net assets are those whose use by Meritus have been limited by donors to a specific time period or purpose. When donor restrictions expire, that is, when a time restriction ends or a purpose restriction is accomplished, restricted net assets are reclassified into unrestricted net assets and reported as net assets released from restrictions. Restricted net assets also include funds that have been restricted by donors to be maintained by Meritus in perpetuity.

Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions if for operating purposes and as other changes in unrestricted net assets if for capital purposes in the consolidated statements of operations and changes in net assets.

(l) (Deficit) Excess of Revenues over Expenses

The consolidated statements of operations include a performance indicator, the excess of revenue over expenses. Changes in unrestricted net assets that are excluded from the excess of revenues over expenses, consistent with industry practice, include net assets released from restrictions for property, plant and equipment, the change in retirement benefit obligation and change in non-controlling interest.

(m) Net Patient Service Revenue

For services provided at the Hospital's campus, all payors are required to pay the Maryland Health Services Cost Review Commission (HSCRC) approved rates. The major third-party payors, as recognized by the HSCRC, are allowed discounts of up to 6% on approved rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered.

The Hospital's charges are subject to review and approval by the HSCRC. The total rate of reimbursement for services to patients under the Medicare and Medicaid programs is based on an arrangement between the Centers for Medicare and Medicaid Service and the HSCRC. The Hospital has an agreement with the HSCRC under a rate regulation concept called Global Budget Revenue (GBR) which was renewed as of July 1, 2016 and renews annually. GBR is a revenue constraint methodology which provides for inflation, bad debt, payor differential and adjustments for population growth, but excludes case mix and volume changes. For the years ended June 30, 2019 and 2018, the regulated revenue cap was $370,257 and $334,576, respectively. For the year ending June 30, 2020, the expected regulated revenue cap is $389,710. The HSCRC also may impose various other revenue adjustments that could be significant in the future.

Services not located on the Hospital's campus and certain other services are not regulated by the HSCRC. Medicare and Medicaid pay the revenues associated with these services based upon established fee schedules. Commercial payors pay at negotiated rates for these services.

(Continued)

Laws and regulations governing the HSCRC, Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Meritus believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action.

The Company adopted Accounting Standards Codification (ASC) 606, Revenue Recognition, effective July 1, 2018 using the modified retrospective transition method. ASC 606 provides a principles-based framework for recognizing revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. Upon adoption, the majority of what was previously classified as provision for uncollectible accounts and presented as a reduction to net patient service revenue in the consolidated statements of operations is treated as a price concession that reduces the transaction price, which is reported as a reduction to net patient service revenue. Other than these changes in presentation, the impact of adopting ASC 606 was not material to consolidated operating revenues, excess of revenues over expenses or total net assets.

Net patient service revenue is recognized, over time, as performance obligations are satisfied. Performance obligations are determined based on the nature of the services provided. Revenue for performance obligations satisfied over time is recognized at the estimated net realizable amounts from patients and third-party payors for services rendered.

The Company generates revenues, primarily by providing healthcare services to its customers. Revenues are recognized when control of the promised good or service is transferred to our customers, in an amount that reflects the consideration to which the Company expects to be entitled from patients, third-party payors (including government programs and insurers) and others, in exchange for those goods and services.

Performance obligations are determined based on the nature of the services provided. The majority of the Company's healthcare services represent a bundle of services that are not capable of being distinct and as such, are treated as a single performance obligation satisfied over time as services are rendered. The Company also provides certain ancillary services which are not included in the bundle of services, and as such, are treated as separate performance obligations satisfied at a point in time, if and when those services are rendered.

The Company's estimate of the transaction price includes estimates of price concessions for such items as contractual allowances, charity care, potential adjustments that may arise from payment and other reviews, and uncollectible amounts, which are determined using a portfolio approach as a practical expedient to account for patient contracts as collective groups rather than individually. Estimates for uncollectible amounts are based on the aging of the accounts receivable, historical collection experience for similar payors and patients, current market conditions, and other relevant factors.

(Continued)

(Dollars in thousands)

Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to net patient service revenue in the period of the change. Subsequent changes that are determined to be the result of an adverse change in the payor's or patient's ability to pay are recorded as bad debt expense. Bad debt expense for the year ended June 30, 2019 was not significant to the consolidated financial statements

Patient service revenue as a percentage for the years ended June 30, 2019 and 2018, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources based on primary insurance designation, is as follows:

Net patient service revenue	payors	Self-pay	payors
2019:			
Patient service revenue, net of contractual allowances and discounts	97 %	3 %	100 %
2018:			
Patient service revenue, net of contractual allowances and discounts	98 %	2 %	100 %

(n) Charity Care

Meritus provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Meritus does not pursue collection on amounts deemed to qualify as charity. Meritus also estimates that the direct and indirect cost of services and supplies furnished to patients eligible for charity care using a ratio of cost to gross charges based on internal data is $9,998 and $10,082 for the years ended June 30, 2019 and 2018, respectively.

Meritus' patient acceptance policy is based upon its mission statement and its charitable purposes. This policy results in Meritus' assumption of higher-than-normal credit risk from its patients. To the extent that Meritus realizes additional losses resulting from such higher credit risks and clients are not identified or do not meet Meritus' defined charity care policy, such additional losses are recognized as a reduction to net patient service revenue.

Meritus also sponsors certain other charitable programs, which provide substantial benefit to the broader community. Such programs include services to needy and elderly populations that require special support, as well as health and education for the general community welfare. In addition, all other uncollectable amounts resulting from the patients' inability to pay are recorded as a reduction to net patient service, consistent with Meritus' policy.

(Continued)

(o) Other Revenue

Other revenue is comprised of rental income, gains and losses on disposal of assets and other miscellaneous items.

(p) Income Taxes

The Internal Revenue Service has ruled that the Hospital, and the Foundation qualify under Section 501(c)(3) of the Internal Revenue Code and are, therefore, not subject to tax under present income tax regulations.

Holdings and MACO are considered a disregarded entity for tax purposes and are reported through the Hospital.

MEI accounts for income taxes through the current recognition of deferred tax liabilities and assets for the expected future tax consequences of temporary differences between tax bases and financial reporting bases of other assets and liabilities.

At present, no income, profit or capital gain taxes are levied in the Cayman Islands and accordingly, no provision for taxation has been made for MIC. In the event that such taxes are levied, MIC has been granted an exemption until September 9, 2023 for any such taxes that might be introduced. MIC intends to conduct its affairs so as not to be liable for taxes in any other jurisdiction.

Meritus follows the accounting guidance for uncertainties in income tax positions, which requires that a tax position be recognized or derecognized based on a "more likely than not" threshold. This applies to positions taken or expected to be taken in a tax return. Meritus does not believe its consolidated financial statements include any material uncertain tax positions. As of June 30, 2019, the Meritus tax years ended June 30, 2015 through June 30, 2019 for federal tax jurisdiction remain open to examination.

On December 22, 2017, the President signed into law H.R. 1, originally known as the Tax Cuts and Jobs Act. The new law includes several provisions that result in substantial changes to the tax treatment of tax-exempt organizations and their donors. The Company has reviewed these provisions and the potential impact and concluded the enactment of H.R. 1 did not have a material impact as of and for the year ended June 30, 2019.

(q) Concentration of Credit Risk

Meritus invests its excess cash, investments, and assets in financial institutions which are federally insured under the Federal Deposit Insurance Act (FDIA). Deposits in certain accounts exceed federally insured deposit limits. Meritus has experienced no losses on its deposits.

Meritus grants credit without collateral to the patients it serves who primarily live in the tri-state area. The majority of these patients have either insurance through Blue Cross, another insurance company or a health maintenance organization, or qualify for the Maryland Medical Assistance or the Centers for Medicare and Medicaid Services (CMS) programs.

(Continued)

(Dollars in thousands)

At June 30, Meritus' patient accounts receivable were made up of the following:

	2019	2018
Medical assistance HMO / Medicaid	22 %	23 %
Medicare	31	30
Commercial insurance, HMO and other	26	21
Blue cross/blue shield	13	10
Self-pay	8	16
	100 %	100 %

(r) Deferred Compensation Plan

The Hospital is party to a 457(b) deferred compensation plan and a 457(f) deferred compensation plan, both are intended to provide retirement benefits to certain eligible employees. Assets are deposited with the plan managers, pursuant to this agreement, such that the value of the assets determined by the fair value approximately equals the related accrued deferred compensation liability. The funds are placed into a range of investment strategies from conservative to aggressive. The liability associated with this plan is included in accrued retirement benefits on the consolidated balance sheets.

(s) Management's Assessment and Plans

The Company adopted Accounting Standards Update (ASU) 2014-5, *Disclosure of Uncertainties about an Entity's Ability to Continue as a Going Concern*, (ASU 2014-15) during 2015. ASU 2014-15 requires management to evaluate an entity's ability to continue as a going concern within one year after the date that the financial statements are issued (or available to be issued, when applicable). Management determined that there were no conditions or events that raise substantial doubt about the Company's ability to continue as a going concern and the Company will continue to meet its obligations through September 27, 2019.

(t) New Accounting Pronouncements

The FASB issued ASU No. 2016-02, *Leases* (ASU 2016-02), which will require lessees to recognize most leases on-balance sheet, increasing their reported assets and liabilities – sometimes very significantly. This update was developed to provide financial statement users with more information about an entity's leasing activities, and will require changes in processes and internal controls. The adoption of ASU 2016-02 is effective fiscal year 2020, and will require application of the new guidance at the beginning of the earliest comparable period presented. Upon adoption, the company expects to record right-to-use assets and obligations for the present value of leases currently classified as operating leases and expect the amount of the right-to-use assets and obligations to be approximately $20,150.

(Continued)

(Dollars in thousands)

(3) Investments and Investment Income

Investments at June 30 consisted of the following:

	2019	2018
Short-term investments:		
US government notes	$ 761	983
Fixed income bonds – corporate	512	437
Mutual funds	33,497	48,125
Total	$ 34,770	49,545
Assets whose use is limited:		
Cash and cash equivalents	$ 10,692	10,536
Fixed income:		
Corporate debt securities	5,391	2,733
Mortgage backed securities	104	150
Asset backed securities	2,047	1,755
US government notes	3,458	3,328
Equities:		
Mutual funds	64,727	67,325
Institutional funds:		
Domestic equities	33,860	16,224
International equities	54,251	57,717
Fixed income	25,291	34,202
Alternative investments	18,160	14,808
Total	$ 217,981	208,778

The amount of the board designated funds whose use is limited is $183,942 and $175,012 as of June 30, 2019 and 2018, respectively.

Investment returns, net of investments included in the consolidated statements of operations and changes in net assets are comprised of the following for the years ended June 30:

	2019	2018
Investment returns, net:		
Interest and dividends, net of investment fees of $572 and $503 in 2019 and 2018, respectively	$ 2,148	1,009
Net realized gains on investments	913	4,220
Change in unrealized gains (losses) on investments	5,575	2,801
	$ 8,636	8,030

(Continued)

(Dollars in thousands)

At June 30, 2019 and 2018, the Hospital had invested $18,160 and $14,808, or 8.3% and 7.0%, respectively, of the portfolio in alternative investments, which are invested in hedge funds. The following table summarizes redemption terms for the hedge fund-of-funds vehicles held as of June 30, 2019:

	Fund 1	Fund 2
Redemption Timing:		
Redemption Frequency	Semi-Annually	Monthly
Required Notice	95 days	30 days

Additionally, at June 30, 2019 and 2018, the Company has invested in $113,402 and $108,143 of institutional funds for which the value is based on either readily determinable fair value (RDFV) or net asset value (NAV). At June 30, 2019, $66,101 was based on RDFV and $47,301 was based on NAV. At June 30, 2018, $37,403 was based on RDFV and $70,740 was based on NAV. The redemption terms and notification requirements of the institutional funds range from daily to monthly.

(4) Fair Value Measurements

Meritus measures fair value as the price that would be received to sell an asset or paid to transfer a liability (the exit price) in an orderly transaction between market participants at the measurement date. The accounting guidance outlines a valuation framework and creates a fair value hierarchy in order to increase the consistency and comparability of fair value measurements and the related disclosures. The fair value hierarchy is broken down into three levels based on the source of inputs as follows:

Level I – Quoted prices are available in active markets for identical assets or liabilities as of the report date. A quoted price for an identical asset or liability in an active market provides the most reliable fair value measurement because it is directly observable to the market.

Level II – Pricing inputs are other than quoted prices in active markets, which are either directly or indirectly observable as of the report date. The nature of these securities include investments for which quoted prices are available but traded less frequently and investments that are fair valued using other securities, the parameters of which can be directly observed.

Level III – Securities that have little to no pricing observability as of the report date. These securities are measured using management's best estimate of fair value, where the inputs into the determination of fair value are not observable and require significant management judgment or estimation.

Financial instruments consist of cash equivalents, patient accounts receivable, investments, excluding those accounted for by the equity method, accounts payable and accrued expenses and long-term debt. The carrying amounts reported in the consolidated balance sheets for cash equivalents, patient accounts receivable, and accounts payable and accrued expenses approximate fair value. Management's estimates of other financial instruments are described elsewhere in the notes to the consolidated financial statements.

Meritus does not have any Level 3 financial instruments as of June 30, 2019 and 2018.

(Continued)

(Dollars in thousands)

Investments are valued using a market approach as follows:

Cash and cash equivalents – Cash and cash equivalents are classified as Level 1 inputs and represent short-term, highly liquid investments that are readily convertible to cash and have original maturities of three months or less.

Stock and equity funds – Common stock and equity funds are Level 1 inputs and consist of stock of U.S. companies and are valued based upon unadjusted quoted prices in the market.

Mutual Funds – Valued at the closing price reported in the active market in which the mutual fund is traded.

Fixed income bonds – Valued at the closing price reported in the active market in which the bond is traded.

The following table presents Meritus' assets measured at fair value on a recurring basis using the market approach, as of June 30:

	Level 1	Level 2	Level 3	Total
2019:				
Cash and cash equivalents	$ 10,693	—	—	10,693
Mutual funds	90,182	—	—	90,182
Fixed income bonds:				
Corporate debt securities	—	5,384	—	5,384
Mortgage backed securities	—	104	—	104
Asset backed securities	—	2,047	—	2,047
U.S. government notes	—	3,458	—	3,458
Institutional funds:				
Domestic equities	—	33,859	—	33,859
International equities	—	17,906	—	17,906
Fixed income	—	14,240	—	14,240
Total assets	$ 100,875	76,998	—	177,873

(Continued)

(Dollars in thousands)

	Level 1	Level 2	Level 3	Total
2018:				
Cash and cash equivalents	$ 10,536	—	—	10,536
Mutual funds	113,404	—	—	113,404
Fixed income bonds:				
Corporate debt securities	—	3,170	—	3,170
Mortgage backed securities	—	150	—	150
Asset backed securities	—	1,755	—	1,755
U.S. government notes	—	4,311	—	4,311
Institutional funds:				
Domestic equities	—	16,224	—	16,224
International equities	—	14,516	—	14,516
Fixed income	—	8,709	—	8,709
Total assets	$ 123,940	48,835	—	172,775

There were no Level 3 investments or transfers during the years ended June 30, 2019 and 2018.

(5) Property, Plant and Equipment

Property, plant and equipment at June 30 is comprised of the following:

	2019	2018
Land	$ 26,099	26,050
Buildings, and improvements	218,152	209,822
Leasehold Improvements	3,184	4,437
Equipment	196,263	171,179
	443,698	411,488
Less accumulated depreciation and amortization	(200,889)	(195,099)
	242,809	216,389
Construction in progress	1,799	35,521
Property, plant and equipment, net	$ 244,608	251,910

Equipment under capital leases	2019	2018
Equipment	$ 9,000	9,000
Less accumulated amortization	(7,120)	(5,320)
	$ 1,880	3,680

(Continued)

(Dollars in thousands)

Total depreciation and amortization expense for property, plant and equipment for the years ended June 30, 2019 and 2018 was $24,975 and $21,135, respectively.

(6) Equity Investments in Affiliates

The following investments, recorded under the equity method of accounting, are included in the consolidated balance sheets.

The Hospital holds a 25% equity interest in Maryland Care, Inc. ("MPC"), a managed care organization (MCO) that was established to serve Maryland's Medicaid population as a result of the State's requirement for Medicaid patients to be a member of an MCO, and Maryland Care Management, Inc. ("MCMI"), a management services organization that provides management services to MPC.

Holdings has a 50% interest in GRI Real Estate and General Surgery Real Estate, both are real estate holding companies. MEI has a 50% interest in Diagnostic Imaging, which provides radiology imaging services.

Summary of financial information as of June 30, 2019 and 2018 and for the years then ended appears below for the significant equity investments:

		Maryland Care, Inc.		MEI Diagnostic Imaging Services, LLC	
		2019	2018	2019	2018
Assets		$ 349,769	341,536	10,670	9,226
Liabilities		231,951	232,207	4,027	1,783
	Equity	$ 117,818	109,329	6,643	7,443
Revenue		$ 1,097,944	1,104,695	20,514	21,328
Expenses		1,098,169	1,098,663	19,113	18,769
	Net income	$ (225)	6,032	1,401	2,559

		Maryland Care Management, Inc.	
		2019	2018
Assets		$ 7,494	9,853
Liabilities		678	612
	Equity	$ 6,816	9,241
Revenue		$ 14,203	—
Expenses		7,328	—
	Net income	$ 6,875	—

(Continued)

(Dollars in thousands)

(7) Long-Term Debt and Leases

Long-term debt at June 30 consists of the following:

	2019	2018
MHHEFA Revenue Bonds:		
Series 2015 3.50%–5.00% serial bonds, including issue premiums of $13,446	$ 258,171	263,156
City of Hagerstown note	20	42
Mortgages and equipment loans with banks, with interest rates ranging from 2.24% to 7.75%	300	381
Capital lease obligations, with interest rates ranging from 1.76% to 2.30%	1,413	3,200
	259,904	266,779
Less current portion of long-term debt	(6,644)	(6,863)
Less debt issuance costs and discounts	(2,027)	(2,105)
	$ 251,233	257,811

On July 9, 2015, Meritus issued Series 2015 Bonds to (i) refund all of the Maryland Health and Higher Educational Facilities Authority's Revenue Bonds, Washington County Hospital Issue, Series 2008 (Series 2008 Bonds), and (ii) finance and refinance the cost of construction, renovation and equipping of certain additional facilities for Meritus (the 2015 Project). The Series 2015 Bonds were issued in the principal amount of $257,300 plus a premium of $15,100. The Series 2015 Bonds proceeds, together with the outstanding Series 2008 Bonds escrow fund balance totaled $22,000, and Meritus' internal cash of $7,400 were used to pay the cost of issuance, refund Series 2008 Bonds and receive $20,000 of proceeds for capital expenditures. The Series 2015 Bonds are due in annual principal installments through 2045, and bear interest at 3.5% to 5.0% due semiannually in January and July.

The long-term debt related to the Series 2015 Bonds is reflected in the consolidated financial statements including the unamortized bond premium. The original issue bond premiums are being amortized over the life of the debt and are netted against interest expense in the consolidated statements of operations and changes in net assets.

All bonds are collateralized by a first lien and claims on all receipts of Meritus, except restricted donations and contributions. In connection with the Series 2015 Bonds, the bond holders have a security interest in existing facilities of Meritus. All bonds require the Hospital to maintain certain financial ratios and stipulated insurance coverage as defined.

Meritus leases equipment under noncancelable lease arrangements. In addition, Meritus leases office space in several locations under operating leases. Some of the leases provide for renewal options. Rent expense under all operating leases was $6,592 and $5,430 for the years ended June 30, 2019 and 2018, respectively.

(Continued)

(Dollars in thousands)

Future minimum lease payments for operating leases and capital leases (with initial or remaining lease terms in excess of one year) as of June 30, 2019 are as follows:

	Operating leases	Capital leases
Year ending June 30:		
2020	$ 2,526	1,428
2021	2,401	—
2022	1,723	—
2023	1,345	
2024	1,295	
Thereafter	17,382	
Total minimum lease payments	$ 26,672	1,428
Less amount representing interest		(14)
Present value of minimum lease payments		$ 1,414

Scheduled principal repayments on long-term debt including payments on capital lease obligations are as follows for the next five years as of June 30:

2020	$ 6,644
2021	5,481
2022	5,672
2023	5,867
2024	6,085
Thereafter	228,128
	$ 257,877

Meritus uses current market prices in determining the fair value of its Revenue Bonds. The carrying value of other long-term debt approximates fair value. The fair value of the Revenue Bonds, was approximately $285,402 and $262,380 at June 30, 2019 and 2018, respectively.

(Continued)

(Dollars in thousands)

(8) Income Taxes

Holdings and its subsidiaries file a consolidated federal return and separate state returns. The income tax (expense) benefit for the years ended June 30, consists of:

	2019	2018
Current:		
Federal	$ (4)	(56)
State	(25)	(18)
	(29)	(74)
Deferred:		
Federal	(23)	(329)
State	(7)	(42)
	(30)	(371)
	$ (59)	(445)

The significant components of the deferred tax assets and deferred tax liabilities, which are included in prepaid and other current assets and other assets at June 30, are as follows:

	2019	2018
Deferred tax asset:		
Accrued vacation	$ 106	96
Deferred compensation	1,093	1,051
Allowance for bad debts	43	20
NOL carryover	1,071	1,175
Fixed assets	97	116
Other	41	20
	2,451	2,478
Deferred tax liabilities:		
Unrealized gain/loss	(10)	(7)
Captive insurance premiums	(9)	(9)
	(19)	(16)
	$ 2,432	2,462

(Continued)

In assessing the reliability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible. Management considers the scheduled reversal of deferred tax liabilities, projected future taxable income, and tax planning strategies in making this assessment. Based upon positive operation trends through 2018, and projections for future taxable income, management believes that it is more likely than not that the Company will realize the benefits of the deductible differences at June 30, 2019 and 2018. Accordingly, the Company has determined that there is no valuation allowance as of June 30, 2019 and 2018. The amount of the deferred tax asset considered realizable, however, could be reduced in the near term if estimates of future taxable income during the carryforward period are reduced.

As of June 30, 2019 and 2018, the Company has no unrecognized tax benefits. Therefore, the Company does not expect any impact on the effective tax rate related to recognition of unrecognized tax benefits. In addition, there are no anticipated reversals of uncertain tax positions in the next twelve months. The Company's policy is to recognize interest and penalties related to unrecognized tax benefits as a component of income tax expense. As of June 30, 2019 and 2018, the Company has no accrued interest or penalties related to uncertain tax positions.

(9) Post Retirement Benefit Plans

Defined Contribution Plans

Meritus has a 401(k) Savings Plan. The plan is available to all Meritus employees. Meritus matches employee contributions for an amount up to 6% of each employee's base salary, subject to limitations. Amounts charged to expense for the years ended June 30, 2019 and 2018 were $5,675 and $5,241, respectively.

The Hospital has frozen a 403(b) plan. Effective July 1, 2011, the plan was frozen to future contributions.

The Hospital and MEI each maintain an employee funded supplemental nonqualified retirement plan for certain employees. The plan requires the benefits be paid upon termination, retirement or death. The related liability is $6,365 and $6,542 at June 30, 2019 and 2018, respectively. Management has designated investments for the intended purpose of funding the liability when payable.

(10) Insurance Coverage

Meritus has a wholly owned insurance captive, MIC, to provide primary limits of insurance of $1,000 per occurrence/$3,000 aggregate for professional and general liability. In addition, MIC purchased reinsurance from an A rated reinsurer in the amount of $25,000 to cover any potential liabilities above the $1,000/$3,000 primary limits, which were covered by MIC. The self-insured liabilities determined by an actuary for professional and general liability claims are included in other long-term liabilities in the consolidated balance sheets. As of June 30, 2019 and 2018, Meritus recorded a liability of $6,257 and $6,770, respectively.

Consistent with most companies with similar insurance operations, the liability for losses is ultimately based on management's reasonable expectations of future events. It is reasonably possible that the expectations

(Continued)

associated with these amounts could change in the near term (i.e., within one year) and that the effect of such changes could be material to the consolidated financial statements.

In 2019 and 2018, the Company participated in a self-insured plan for workers' compensation claims. Stop-loss coverage has been purchased through a commercial carrier for claims in excess of $300 and not to exceed $700. As of June 30, 2019 and 2018, Meritus recorded a liability of $3,300, which is included in accrued salaries, wages and withholdings in the consolidated balance sheets.

(11) Risk and Uncertainties

The Company provides general acute healthcare services in the State of Maryland. The Company and other healthcare providers are subject to certain inherent risks, including the following:

- Dependence on revenues derived from reimbursement by the federal Medicare and state Medicaid programs
- Regulation of hospital rates by the State of Maryland Health Services Cost Review Commission
- Government regulation, government budgetary constraints and proposed legislative and regulatory changes, and
- Lawsuits alleging malpractice or other claims

Such inherent risks require the use of certain management estimates in the preparation of the Company's consolidated financial statements and it is reasonably possible that a change in such estimates may occur.

The Medicare and state Medicaid reimbursement programs represent a substantial portion of the Company's revenues and the Company's operations are subject to a variety of other federal, state and local regulatory requirements. Failure to maintain required regulatory approvals and licenses and/or changes in such regulatory requirements could have a significant adverse effect on the Company.

Changes in federal and state reimbursement funding mechanisms and related government budgetary constraints could have a significant adverse effect on the Company.

The federal government and many states have aggressively increased enforcement under Medicare and Medicaid anti-fraud and abuse laws and physician self-referral laws (STARK law and regulation). Federal healthcare reform initiatives continue to prompt a national review of federally funded healthcare programs. In addition, the federal government and many states continue to fund programs to audit and recover potential overpayments to providers from the Medicare and Medicaid programs. The Company has devoted resources to implement a compliance program to monitor conformance with applicable laws and regulations, but the possibility of future government review and enforcement action exists. However, any negative findings from a future proceeding, if any, could result in substantial financial penalties or awards against the Company, exclusion from future participation in the Medicare and Medicaid programs and if criminal proceedings were initiated against the Company, possible criminal penalties. At this time, the Company cannot predict the ultimate outcome of any potential inquiries, or the potential range of damages, if any.

(Continued)

(Dollars in thousands)

As a result of recently enacted and pending federal healthcare reform legislation, substantial changes are anticipated in the United States healthcare system. Such legislation includes numerous provisions affecting the delivery of healthcare services, the financing of healthcare costs, reimbursement to healthcare providers and the legal obligations of health insurers, providers and employers. These provisions are currently slated to take effect at specified times over the next decade. This federal healthcare reform legislation did not affect the 2019 or 2018 consolidated financial statements.

Litigation

Additionally, Meritus is involved in litigation and regulatory investigations arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without a material adverse effect on Meritus' financial position or results of operations.

(12) Functional Expenses

Meritus provides general healthcare services to residents within its geographic location. Expenses related to providing these services for the years ended June 30 are as follows:

2019:

	Program Services	General and Administrative	Fundraising	Total
Salaries and wages	$ 124,607	35,933	—	160,540
Employee benefits	28,889	7,222	—	36,111
Professional fees	12,723	3,181	—	15,904
Supplies and other	122,974	30,743	191	153,908
Interest	9,159	2,290	—	11,449
Depreciation and amortization	19,980	4,995	—	24,975
Total Expenses	$ 318,332	84,364	191	402,887

2018:

	Program Services	General and Administrative	Fundraising	Total
Salaries and wages	$ 113,202	32,409	—	145,611
Employee benefits	27,722	6,930	—	34,652
Professional fees	12,019	3,005	—	15,024
Supplies and other	122,520	30,630	185	153,335
Interest	6,869	4,850	—	11,719
Depreciation and amortization	12,681	8,454	—	21,135
Total Expenses	$ 295,013	86,278	185	381,476

(Continued)

(Dollars in thousands)

(13) Liquidity and Availability of Financial Assets

The following reflects financial assets as of June 30, 2019, reduced by amounts not available for general expenditure because of contractual or donor-imposed restrictions within one year.

Financial assets as of June 30, 2019	$	327,848
Less those unavailable for general expenditures within on year, due to:		
Contractual and donor-imposed restriction:		
Funds designated for insurance purpose		(16,470)
Assets held by trustee		(10,577)
Supplemental retirement benefits investment		(5,848)
Donor restricted		(1,144)
Financial assets available within one year to meet cash needs for general expenditures within one year	$	293,809

Included in financial assets available are $183,942 of funds set aside for long-term investments as designated by the Board of Directors.

(14) Subsequent Events

Meritus evaluated subsequent events through October 2, 2019, the date these consolidated financial statements were available to be issued. All material matters are disclosed in the notes to the consolidated financial statements.

SUPPLEMENTARY INFORMATION

MERITUS MEDICAL CENTER, INC.

Consolidating Balance Sheet

June 30, 2019

(Dollars in thousands)

Assets	Meritus Medical Center	Meritus Healthcare Foundation	Meritus other	Consolidating total
Current assets:				
Cash and cash equivalents	$ 30,705	—	1,335	32,040
Short-term investments	34,770	—	—	34,770
Current portion of assets whose use is limited	10,577	—	—	10,577
Accounts receivable	48,450	34	5,036	53,520
Supplies	5,029	—	754	5,783
Prepaid and other current assets	26,741	(324)	995	27,412
Total current assets	156,272	(290)	8,120	164,102
Assets limited as to use	179,733	7,898	19,773	207,404
Property, plant and equipment, net	239,750	—	4,858	244,608
Equity investments in affiliates	36,325	—	3,457	39,782
Other assets	8,900	146	3,538	12,584
Total assets	$ 620,980	7,754	39,746	668,480

MERITUS MEDICAL CENTER, INC.

Consolidating Balance Sheet

June 30, 2019

(Dollars in thousands)

Liabilities and Net Assets	Meritus Medical Center	Meritus Healthcare Foundation	Meritus other	Consolidating total	Cons e
Current liabilities:					
Accounts payable and accrued expenses	$ 12,756	87	28,652	41,495	
Accrued salaries, wages and withholdings	11,789	—	1,311	13,100	
Accrued compensation benefit	9,673	12	2,733	12,418	
Advances from third party payors	13,162	—	488	13,650	
Accrued interest payable	5,928	—	—	5,928	
Current maturity of long-term debt	6,596	—	48	6,644	
Total current liabilities	59,904	99	33,232	93,235	
Long term debt, net of current portion	251,121	—	112	251,233	
Accrued retirement benefits	2,392	—	3,973	6,365	
Other long term liabilities	—	—	16,761	16,761	
Total liabilities	313,417	99	54,078	367,594	
Stockholder's equity:					
Common stock	—	—	820	820	
Paid-in capital	—	—	1,150	1,150	
Retained earnings	—	—	(1,490)	(1,490)	
Total stockholders' equity	—	—	480	480	
Net assets:					
Unrestricted	301,542	3,072	(14,812)	289,802	
Restricted net assets	6,021	4,583	—	10,604	
Total net assets	307,563	7,655	(14,812)	300,406	
Total liabilities and net assets	$ 620,980	7,754	39,746	668,480	

See accompanying independent auditors' report.

MERITUS MEDICAL CENTER, INC.

Consolidating Statement of Operations and Change in Net Assets

Year ended June 30, 2019

(Dollars in thousands)

Fiscal period ending June 30, 2019	Meritus Medical Center	Meritus Healthcare Foundation	Meritus other	Consolidating total
Unrestricted revenue, gains and other support:				
Net patient revenue	$ 321,342	—	67,445	388,787
Other revenue	10,944	79	1,095	12,118
Equity earnings in affiliates	3,826	—	746	4,572
Net assets released from restriction used for operations	832	790	—	1,622
	336,944	869	69,286	407,099
Operating expenses:				
Salaries and wages	123,429	287	36,824	160,540
Benefits	29,607	78	6,756	36,441
Professional fees	15,570	—	334	15,904
Supplies and other	128,048	150	39,824	168,022
Interest	11,443	—	6	11,449
Depreciation and amortization	23,659	—	1,316	24,975
	331,756	515	85,060	417,331
Operating income (loss)	5,188	354	(15,774)	(10,232)
Nonoperating gains (losses), net:				
Investment returns, net	7,283	337	1,016	8,636
Other, net	(65)	(660)	—	(725)
Income tax expense	(5)	—	(54)	(59)
Excess (deficit) of revenue over expenses	$ 12,401	31	(14,812)	(2,380)

MERITUS MEDICAL CENTER, INC.

Consolidating Statement of Operations and Change in Net Assets

Year ended June 30, 2019

(Dollars in thousands)

Fiscal period ending June 30, 2019	Meritus Medical Center	Meritus Healthcare Foundation	Meritus other	Consolidating total
Unrestricted net assets:				
Excess (deficit) of revenues over expenses	$ 12,401	31	(14,812)	(2,380)
Other	—	164	—	164
Increase (decrease) in unrestricted net assets	12,401	195	(14,812)	(2,216)
Restricted net assets:				
Contributions	974	701	—	1,675
Other	(114)	(117)	—	(231)
Net assets released to restriction for operations	(832)	(790)	—	(1,622)
Increase (decrease) restricted net assets	28	(206)	—	(178)
Increase (decrease) in net assets	12,429	(11)	(14,812)	(2,394)
Net assets:				
Beginning of year	295,134	7,666	480	303,280
End of year	$ 307,563	7,655	(14,332)	300,886

See accompanying independent auditors' report.

KPMG

MERITUS MEDICAL CENTER, INC.

Consolidated Financial Statements and
Supplementary Financial Information

June 30, 2020 and 2019

(With Independent Auditors' Report Thereon)

MERITUS MEDICAL CENTER, INC.

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KPMG LLP
750 East Pratt Street, 18th Floor
Baltimore, MD 21202

Independent Auditors' Report

The Board of Directors
Meritus Medical Center, Inc.:

We have audited the accompanying consolidated financial statements of Meritus Medical Center, Inc. (Meritus), which comprise the consolidated balance sheets as of June 30, 2020 and 2019, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Meritus as of June 30, 2020 and 2019, and the results of its operations and changes in net assets and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Emphasis of Matter

As discussed in note 2(t) and note 8 to the consolidated financial statements, Meritus adopted Financial Accounting Standards Board Accounting Standards Update (ASU) 2016-02, *Leases (Topic 842)* during the year ended June 30, 2020. Our opinion is not modified with respect to this matter.

As discussed in note 2(m) to the consolidated financial statements, Meritus adopted Financial Accounting Standards Board ASU No. 2014-19, *Revenue from Contracts with Customers (Topic 606)* and ASU No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities* during the year ended June 30, 2019. Our opinion is not modified with respect to this matter.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Schedules 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

Baltimore, Maryland
October 2, 2020

MERITUS MEDICAL CENTER, INC.

Consolidated Balance Sheets

June 30, 2020 and 2019

(Dollars in thousands)

Assets		2020	2019
Current assets:			
Cash and cash equivalents	$	15,561	32,040
Short-term investments		126,524	34,770
Current portion of assets whose use is limited		10,691	10,577
Accounts receivable		31,644	41,028
Supplies		6,347	5,783
Prepaid and other current assets		10,478	6,142
Total current assets		201,245	130,340
Assets whose use is limited		212,962	207,404
Property, plant and equipment, net		235,138	244,608
Equity investments in affiliates		40,204	36,658
Other assets		23,885	8,001
Total assets	$	713,434	627,011
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	26,055	18,195
Accrued salaries, wages and withholdings		14,754	13,100
Accrued compensation benefit		13,828	12,418
Advances from third-party payors		79,736	13,650
Accrued interest payable		5,808	5,928
Current portion of long-term debt		5,481	6,644
Total current liabilities		145,662	69,935
Long-term debt, net of current portion		245,751	251,233
Accrued retirement benefits		6,379	6,365
Other long-term liabilities		21,530	6,298
Total liabilities		419,322	333,831
Net assets:			
Unrestricted		288,377	287,159
Restricted		5,735	6,021
Total net assets		294,112	293,180
Total liabilities and net assets	$	713,434	627,011

See accompanying notes to consolidated financial statements.

MERITUS MEDICAL CENTER, INC.

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2020 and 2019

(Dollars in thousands)

	2020	2019
Unrestricted revenue, gains and other support:		
Net patient service revenue	$ 367,971	376,849
Other revenue	21,831	9,612
Equity earnings in affiliates	4,448	4,572
Net assets released from restriction used for operations	1,133	1,045
Total revenues	395,383	392,078
Expenses:		
Salaries and wages	166,928	160,540
Employee benefits	37,416	36,111
Professional fees	16,521	15,904
Supplies and other	141,264	153,908
Interest	11,203	11,449
Depreciation and amortization	26,007	24,975
Total expenses	399,339	402,887
Operating losses	(3,956)	(10,809)
Nonoperating gains (losses), net:		
Investment returns, net	4,877	8,636
Other, net	(75)	(148)
Income tax expense	(333)	(59)
Excess (deficit) of revenues over expenses	$ 513	(2,380)

(Continued)

MERITUS MEDICAL CENTER, INC.

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2020 and 2019

(Dollars in thousands)

	2020	2019
Unrestricted net assets:		
Excess (deficit) of revenues over expenses	$ 513	(2,380)
Other	705	16
Increase (decrease) in unrestricted net assets	1,218	(2,364)
Restricted net assets:		
Contributions	689	1,098
Other	158	(25)
Net assets released from restriction for operations	(1,133)	(1,045)
(Decrease) increase in restricted net assets	(286)	28
Increase (decrease) in net assets	932	(2,336)
Net assets:		
Beginning of year	293,180	295,516
End of year	$ 294,112	293,180

See accompanying notes to the consolidated financial statements.

MERITUS MEDICAL CENTER, INC.

Consolidated Statements of Cash Flows

Years ended June 30, 2020 and 2019

(Dollars in thousands)

	2020	2019
Cash flows from operating activities:		
Increase (decrease) in net assets	$ 932	(2,336)
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	26,007	24,975
Net realized and unrealized gains on investments	(2,949)	(6,488)
(Gain) loss on disposal of assets	134	(1,181)
Equity earnings in affiliates	(4,448)	(4,572)
Restricted contributions and other	(1,552)	(1,089)
Changes in assets and liabilities:		
Accounts receivable	9,384	952
Supplies, prepaid, and other current assets	(4,900)	49
Other assets	(15,883)	(4,039)
Accounts payable, accrued expenses and long-term liabilities	23,092	(4,609)
Accrued salaries, wages and withholdings	1,654	2,038
Accrued compensation benefit	1,410	1,363
Advances from third-party payors	66,086	(861)
Interest payable	(120)	(110)
Accrued retirement benefits	14	(177)
Net cash provided by operating activities	98,861	3,915
Cash flows from investing activities:		
Purchase of property, plant and equipment	(17,111)	(17,737)
Proceeds from the disposal of assets	440	1,245
Purchases of short term investments using advances from third party payors	(66,000)	—
Purchases of alternative investments	—	(425)
(Purchases)/sales of short-term investments, and assets whose use is limited, net	(28,478)	12,485
Equity contributions to affiliates, net	902	1,295
Net cash used in investing activities	(110,247)	(3,137)
Cash flows from financing activities:		
Payments on long-term debt and capital leases	(6,645)	(6,798)
Restricted contributions and other	1,552	1,089
Net cash used in financing activities	(5,093)	(5,709)
Net decrease in cash and cash equivalents	(16,479)	(4,931)
Cash and cash equivalents:		
Beginning of year	32,040	36,971
End of year	$ 15,561	32,040
Supplemental disclosure of cash flow information:		
Cash paid for interest	$ 11,203	11,449
Cash paid for income taxes	144	113

See accompanying notes to consolidated financial statements.

(1) Description of Organization

Organization

Meritus Medical Center, Inc. (the Hospital or the Company) is the parent corporation of the Meritus Healthcare Foundation, Inc. (the Foundation), the Meritus Insurance Company, Ltd. (MIC), Meritus Health ACO, LLC (MACO) and Meritus Holdings, LLC (Holdings), which owns Meritus Enterprises (MEI). These entities are collectively referred to as "Meritus".

The Hospital is a not-for-profit acute care hospital located in Hagerstown, Maryland and serves the residents of western Maryland, southern Pennsylvania, and the panhandle of West Virginia. The Hospital currently offers acute general hospital inpatient services, including adult medical/surgical care, obstetrics and newborn care, including a family birthing center, cardiac catheterizations, comprehensive inpatient rehabilitation, radiology and diagnostic services, inpatient and outpatient mental health services, a regional Level III Trauma Center, an intensive care unit, an intermediate care unit, and a pediatric unit. The Hospital also manages gifts, donations or bequests given for the benefit of Meritus and owns real estate properties for rental to medical provider entities and development opportunities.

The Foundation is a not-for-profit corporation whose purpose is to raise philanthropic support for the capital and endowment campaigns of the Hospital. The Foundation also raises money for the Hospital's medical programs, healthcare objectives, scientific research, educational programs, and related community activities. Resources for the Foundation's activities are primarily provided by donors.

MIC is a Cayman Island captive insurance company, wholly owned by the Hospital that provides primary limits of insurance to Meritus for professional liability, employed physician's professional liability, comprehensive general liability, deductible, and stop-loss coverage for health insurance.

As of June 30, 2020, MEI, a for-profit corporation, held ownership interests in the following joint venture:

- Diagnostic Imaging Services, LLC (DIS), an outpatient imaging services provider

Holdings is the sole member of Medical Practices of Antietam, LLC, which employs physicians and operates clinics in the Meritus primary service area.

As of June 30, 2020, Holdings, held ownership interests in the following joint venture:

- General Surgery Real Estate, LLC (GSRE), a real estate holding company

MEI also owns and operates Equipped for Life, a durable medical equipment company (EFL).

MACO is an Accountable Care Organization (ACO), wholly owned by the Hospital. MACO participates in the following CMS programs:

- Medicare Shared Savings Plan ("MSSP"), effective January 1, 2017 through December 31, 2019
- Maryland Primary Care Program ("MDPCP"), as an approved Care Transformation Organization for Washington County, MD, effective January 1, 2019

(Continued)

(2) Summary of Significant Accounting Policies

(a) Principles of Consolidation

The Company's consolidated financial statements include the subsidiaries in which the Company has more than 50% voting interests or when the Company is deemed to have control. Significant intercompany accounts and transactions have been eliminated in consolidation. The accompanying consolidated financial statements include the accounts of the Hospital, Holdings, MEI, the Foundation, MACO, and MIC. All material inter-company balances and transactions have been eliminated in consolidation.

(b) Use of Estimates

The preparation of consolidated financial statements, in conformity with accounting principles generally accepted in the United States of America, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Accordingly, actual results could differ from those estimates.

(c) Cash and Cash Equivalents

Cash and cash equivalents consist of short-term, highly liquid investments that are readily convertible to cash and have original maturities of three months or less. Cash and cash equivalents are carried at cost which approximates fair value.

(d) Patient Accounts Receivable

Patient accounts receivable result from the healthcare services provided by Meritus and are recorded at the net realizable value based on certain assumptions determined by each payor. For third-party payors, including Medicare, Medicaid, and commercial insurance, the net realizable value is based on the estimated contract adjustments, which is based on approved discounts on charges as permitted by the Health Services Cost Review Commission (HSCRC). For self-pay accounts, which included patients who are uninsured and the patient responsibility portion for patients with insurance, the net realizable value is determined using estimates of historical collection experience. See note 2(m) for revenue recognition policies.

(e) Assets Whose Use is Limited

Assets whose use is limited include assets set aside by the Board of Directors for specific purposes, for supplemental retirement benefit investments, to fulfill donor purposes, assets held by trustees under bond indenture agreement, and funds designated for insurance purposes. Amounts required to meet current liabilities are shown as current assets in the consolidated balance sheets. Cash and cash equivalents, as defined above, within assets whose use is limited are treated as investments.

(Continued)

(f) Investments and Investment Income

Investments in equity securities (i.e., investments that have readily determinable fair values and are not accounted for by the equity method) and all investments in debt securities are reported at fair value on the consolidated balance sheets. Institutional funds are recorded at their readily determinable fair values (RDFV). All securities with the exception of alternative investments are reported at fair value. Alternative investments are recorded under the equity method of accounting.

A significant portion of the Meritus' investments are held in an investment portfolio maintained for the benefit of Meritus and its affiliates and its subsidiaries. Investments are classified as trading securities except for certain investments, which are limited or restricted as to use or do not have the liquidity to qualify as trading securities and are classified as investments available for sale.

Investment income and realized gains are recorded as nonoperating revenue. Unrealized gains and losses on trading securities are recorded as nonoperating revenue. Unrealized gains and losses on available for sale investments are included in other changes in net assets. Investment income and realized gains and losses on assets restricted by donors for specific purposes or endowment are included in restricted net assets.

Investment income, which includes interest and dividends, on proceeds of borrowings that are held by a trustee are reported as other revenue. Other investment income, which includes interest, dividends and realized and unrealized gains and losses on assets limited as to use by Board of Directors and funds designated for insurance purposes are recorded as nonoperating gains (losses), net, unless the income or loss is restricted by donor or law.

Meritus' investments are managed by investment managers. Investment securities, in general, are exposed to various risks, such as interest rate, credit and overall market volatility. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near term and that such change could materially affect the amounts reported in the consolidated financial statements.

(g) Supplies

Supplies for the Hospital are carried at cost on a weighted average basis.

(h) Property, Plant and Equipment

Property, plant and equipment acquisitions are recorded at cost. Those assets acquired by gift are carried at amounts established as fair value at the time of acquisition. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Equipment under finance leases are amortized by the straight-line method over the shorter of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the consolidated financial statements. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. No interest was capitalized during the years ended June 30, 2020 and 2019. Leasehold improvements are amortized over the lesser of the useful life or the lease life. Durable medical equipment held for resale is included in supplies. The remainder of durable medical equipment

(Continued)

is rented to patients and is included in property, plant and equipment. Assets are retired or disposed of at book value and related gains or losses are recorded for assets sold. Useful lives range as follows:

Land improvements	5–25 years
Buildings	10–40 years
Equipment	3–20 years
Leasehold improvements	The lesser of the useful life or lease term

Gifts of long-lived assets such as land, buildings, or equipment are reported as other changes in unrestricted net assets unless explicit donor stipulations specify how the donated assets must be used. When applicable, gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long-lived assets must be maintained, expirations of donor restrictions, occur when the donated or acquired long-lived assets are placed into service.

Meritus continually evaluates whether events and circumstances have occurred that indicate the remaining estimated useful life of long-lived assets is appropriate, or whether the remaining balance may not be recoverable. When factors indicate that long-lived assets should be evaluated for possible impairment, Meritus uses an estimate of the related undiscounted operating income over the remaining life of the long lived asset in measuring whether the long-lived asset is recoverable.

The impairment loss on these assets is measured as the excess of the carrying amount of the asset over its fair value. Fair value is based upon market prices, where available, or discounted cash flows. Management believes that no revision to the remaining useful lives is required and there was no impairment of long-lived assets during the years ended June 30, 2020 and 2019.

(i) Deferred Financing Costs

Financing costs incurred in issuing debt have been capitalized and are being amortized over the life of the debt using the effective interest method.

(j) Compensated Absences

Meritus records a liability for amounts due to employees for future absences which are attributable to services performed in the current and prior periods. This liability is included in accrued compensation benefit on the consolidated balance sheets.

(Continued)

(k) Restricted Net Assets

Restricted net assets are those whose use by Meritus have been limited by donors to a specific time period or purpose. When donor restrictions expire, that is, when a time restriction ends or a purpose restriction is accomplished, restricted net assets are reclassified into unrestricted net assets and reported as net assets released from restrictions. Restricted net assets also include funds that have been restricted by donors to be maintained by Meritus in perpetuity.

Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions if for operating purposes and as other changes in unrestricted net assets if for capital purposes in the consolidated statements of operations and changes in net assets.

(l) Excess (Deficit) of Revenues over Expenses

The consolidated statements of operations include a performance indicator, the excess (deficit) of revenue over expenses. Changes in unrestricted net assets that are excluded from the excess (deficit) of revenues over expenses, consistent with industry practice, include net assets released from restrictions for property, plant and equipment.

(m) Net Patient Service Revenue

For services provided at the Hospital's campus, all payors are required to pay the Maryland Health Services Cost Review Commission (HSCRC) approved rates. The major third-party payors, as recognized by the HSCRC, are allowed discounts of up to 6% on approved rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered.

The Hospital's charges are subject to review and approval by the HSCRC. The total rate of reimbursement for services to patients under the Medicare and Medicaid programs is based on an arrangement between the Centers for Medicare and Medicaid Service and the HSCRC. The Hospital has an agreement with the HSCRC under a rate regulation concept called Global Budget Revenue (GBR) which was renewed as of July 1, 2016 and renews annually. GBR is a revenue constraint methodology which provides for inflation, bad debt, payor differential and adjustments for population growth, but excludes case mix and volume changes. For the years ended June 30, 2020 and 2019, the regulated revenue cap was $396,395 and $370,257, respectively. The Hospital was below its GBR regulated revenue cap in the current year mainly due to the impact of COVID-19 (see note 15). The HSCRC issued regulations due to the impact of COVID-19 on all hospitals in Maryland that allows hospitals to carry over any undercharge less amount recouped from other federal programs to the following fiscal year GBR regulated revenue cap. The HSCRC also may impose various other revenue adjustments that could be significant in the future.

Services not located on the Hospital's campus and certain other services are not regulated by the HSCRC. Medicare and Medicaid pay the revenues associated with these services based upon established fee schedules. Commercial payors pay at negotiated rates for these services.

(Continued)

Laws and regulations governing the HSCRC, Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Meritus believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action.

The Company adopted Topic 606, Revenue Recognition, effective July 1, 2018 using the modified retrospective transition method. Topic 606 provides a principles-based framework for recognizing revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. Upon adoption, the majority of what was previously classified as provision for uncollectible accounts and presented as a reduction to net patient service revenue in the consolidated statements of operations is treated as a price concession that reduces the transaction price, which is reported as a reduction to net patient service revenue. Other than these changes in presentation, the impact of adopting ASC 606 was not material to consolidated operating revenues, excess of revenues over expenses or total net assets.

Net patient service revenue is recognized, over time, as performance obligations are satisfied. Performance obligations are determined based on the nature of the services provided. Revenue for performance obligations satisfied over time is recognized at the estimated net realizable amounts from patients and third-party payors for services rendered.

The Company generates revenues, primarily by providing healthcare services to its customers. Revenues are recognized when control of the promised good or service is transferred to our customers, in an amount that reflects the consideration to which the Company expects to be entitled from patients, third-party payors (including government programs and insurers) and others, in exchange for those goods and services.

The majority of the Company's healthcare services represent a bundle of services that are not capable of being distinct and as such, are treated as a single performance obligation satisfied over time as services are rendered. The Company also provides certain ancillary services which are not included in the bundle of services, and as such, are treated as separate performance obligations satisfied at a point in time, if and when those services are rendered.

The Company's estimate of the transaction price includes estimates of price concessions for such items as contractual allowances, charity care, potential adjustments that may arise from payment and other reviews, and uncollectible amounts, which are determined using a portfolio approach as a practical expedient to account for patient contracts as collective groups rather than individually. Estimates for uncollectible amounts are based on the aging of the accounts receivable, historical collection experience for similar payors and patients, current market conditions, and other relevant factors.

(Continued)

(Dollars in thousands)

Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to net patient service revenue in the period of the change. Subsequent changes that are determined to be the result of an adverse change in the payor's or patient's ability to pay are recorded as bad debt expense. Bad debt expense for the year ended June 30, 2020 and 2019 was not significant to the consolidated financial statements

Patient service revenue as a percentage for the years ended June 30, 2020 and 2019, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources based on primary insurance designation, is as follows:

	Third-party 2020	2019
Net patient service revenue:		
Hospital inpatient	$ 209,984	209,568
Hospital outpatient	155,736	160,394
Other outpatient	143,862	151,709
Gross charges	509,582	521,671
Less contractual and other allowances	(141,611)	(144,822)
Net patient service revenue	$ 367,971	376,849

(n) Charity Care

Meritus provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Meritus does not pursue collection on amounts deemed to qualify as charity. Meritus also estimates that the direct and indirect cost of services and supplies furnished to patients eligible for charity care using a ratio of cost to gross charges based on internal data is $11,889 and $9,998 for the years ended June 30, 2020 and 2019, respectively.

Meritus' patient acceptance policy is based upon its mission statement and its charitable purposes. This policy results in Meritus' assumption of higher-than-normal credit risk from its patients. To the extent that Meritus realizes additional losses resulting from such higher credit risks and clients are not identified or do not meet Meritus' defined charity care policy, such additional losses are recognized as a reduction to net patient service revenue.

Meritus also sponsors certain other charitable programs, which provide substantial benefit to the broader community. Such programs include services to needy and elderly populations that require special support, as well as health and education for the general community welfare. In addition, all other uncollectable amounts resulting from the patients' inability to pay are recorded as a reduction to net patient service revenue, consistent with Meritus' policy.

(Continued)

(o) Other Revenue

Other revenue is comprised of rental income, gains and losses on disposal of assets, grants related to Covid-19 funding including CARES Act funding (see note 14) and other miscellaneous items.

(p) Income Taxes

The Internal Revenue Service has ruled that the Hospital, and the Foundation qualify under Section 501(c)(3) of the Internal Revenue Code and are, therefore, not subject to tax under present income tax regulations.

Holdings and MACO are considered a disregarded entity for tax purposes and are reported through the Hospital.

MEI accounts for income taxes through the current recognition of deferred tax liabilities and assets for the expected future tax consequences of temporary differences between tax bases and financial reporting bases of other assets and liabilities.

At present, no income, profit or capital gain taxes are levied in the Cayman Islands and accordingly, no provision for taxation has been made for MIC. In the event that such taxes are levied, MIC has been granted an exemption until September 9, 2023 for any such taxes that might be introduced. MIC intends to conduct its affairs so as not to be liable for taxes in any other jurisdiction.

Meritus follows the accounting guidance for uncertainties in income tax positions, which requires that a tax position be recognized or derecognized based on a "more likely than not" threshold. This applies to positions taken or expected to be taken in a tax return. Meritus does not believe its consolidated financial statements include any material uncertain tax positions. As of June 30, 2020, the Meritus tax years ended June 30, 2016 through June 30, 2020 for federal tax jurisdiction remain open to examination.

(q) Concentration of Credit Risk

Meritus invests its excess cash, investments, and assets in financial institutions which are federally insured under the Federal Deposit Insurance Act (FDIA). Deposits in certain accounts exceed federally insured deposit limits. Meritus has experienced no losses on its deposits.

Meritus grants credit without collateral to the patients it serves who primarily live in the tri-state area. The majority of these patients have either insurance through Blue Cross, another insurance company or a health maintenance organization, or qualify for the Maryland Medical Assistance or the Centers for Medicare and Medicaid Services (CMS) programs.

(Continued)

(Dollars in thousands)

At June 30, Meritus' patient accounts receivable was made up of the following:

	2020	2019
Medical assistance HMO/Medicaid	22 %	22 %
Medicare	35	31
Commercial insurance, HMO and other	22	26
Blue cross/blue shield	12	13
Self-pay	9	8
	100 %	100 %

(r) Deferred Compensation Plan

The Hospital is party to a 457(b) deferred compensation plan and a 457(f) deferred compensation plan, both are intended to provide retirement benefits to certain eligible employees. Assets are deposited with the plan managers, pursuant to this agreement, such that the value of the assets determined by the fair value approximately equals the related accrued deferred compensation liability. The funds are placed into a range of investment strategies from conservative to aggressive. The liability associated with this plan is included in accrued retirement benefits on the consolidated balance sheets.

(s) Management's Assessment and Plans

The Company adopted ASU 2014-5, *Disclosure of Uncertainties about an Entity's Ability to Continue as a Going Concern*, (ASU 2014-15) during 2015. ASU 2014-15 requires management to evaluate an entity's ability to continue as a going concern within one year after the date that the financial statements are issued (or available to be issued, when applicable). Management determined that there were no conditions or events that raise substantial doubt about the Company's ability to continue as a going concern and the Company will continue to meet its obligations through October 3, 2021.

(t) Leases

In February 2016, FASB issued ASU No. 2016-02, *Leases* (ASU 2016-02). The standard requires Meritus to recognize the assets and liabilities related to leases on the balance sheet. Additionally, in July 2018, FASB issued ASU-2018-11, *Leases* – Targeted Improvements, which provides an additional transition method that would allow entities to not apply the guidance in ASU 2016-02 in the comparative periods presented in the financial statements and instead recognize a cumulative-effect adjustment to the opening balance of retained earnings in the period of adoption. Meritus adopted ASU 2016-02 and its related amendments as of July 1, 2019, using the modified retrospective method applying the transition provisions at the beginning of the period of adoption, rather than at the beginning of the earliest comparative period presented, which resulted in the recognition of operating right-of-use assets totaling $22,248 and operating right-of-use liabilities totaling $22,248. There was no cumulative effect adjustment to the opening balance of retained earnings required.

(Continued)

(Dollars in thousands)

The Company has elected the practical expedient package to not reassess at adoption (i) expired or existing contracts for whether they are or contain a lease, (ii) the lease classification of any existing leases or (iii) initial indirect costs for existing leases. We have also elected the policy exemption that allows lessees to choose to not separate lease and non-lease components by class of underlying asset and are applying this expedient to all relevant asset classes.

The adoption of ASC 842 had a material impact on the Company's consolidated balance sheet through the recording of the operating lease liabilities and related ROU assets for leases in effect at July 1, 2019, but the adoption did not have a material impact on the Company's consolidated statement of operations or consolidated statement of cash flows for the year ended June 30, 2020. Additional lease disclosures can be found in Note 8.

(3) Investments and Investment Income

Investments at June 30 consisted of the following:

	2020	2019
Short-term investments:		
US government notes	$ 16,602	761
Fixed income bonds – corporate	42,857	512
Mutual funds	1,065	33,497
Certificates of deposit	66,000	—
Total	$ 126,524	34,770
Assets whose use is limited:		
Cash and cash equivalents	$ 17,957	10,692
Fixed income:		
Corporate debt securities	6,587	5,391
Mortgage backed securities	227	104
Asset backed securities	2,439	2,047
US government notes	4,691	3,458
Equities:		
Mutual funds	63,005	64,727
Institutional funds:		
Domestic equities	39,105	33,860
International equities	52,721	54,251
Fixed income	19,897	25,291
Alternative investments	17,024	18,160
Total	$ 223,653	217,981

The amount of the board designated funds whose use is limited is $187,829 and $183,942 as of June 30, 2020 and 2019, respectively.

(Continued)

(Dollars in thousands)

Investment returns, net of investments included in the consolidated statements of operations and changes in net assets are comprised of the following for the years ended June 30:

	2020	2019
Investment returns, net:		
Interest and dividends, net of investment fees of $602 and $572 in 2020 and 2019, respectively	$ 1,928	2,148
Net realized gains on investments	2,381	913
Change in unrealized gains on investments	568	5,575
	$ 4,877	8,636

At June 30, 2020 and 2019, the Hospital had invested $17,204 and $18,160, or 7.6% and 8.3%, respectively, of the portfolio in alternative investments, which are invested in hedge funds. The following table summarizes redemption terms for the hedge fund-of-funds vehicles held as of June 30, 2020:

	Fund 1	Fund 2
Redemption timing:		
Redemption frequency	Semi-Annually	Monthly
Required notice	95 days	30 days

Additionally, at June 30, 2020 and 2019, the Company has invested in $112,964 and $113,402 of institutional funds for which the value is based on either readily determinable fair value (RDFV) or net asset value (NAV). At June 30, 2020, $49,313 was based on RDFV and $63,651 was based on NAV. At June 30, 2019, $66,101 was based on RDFV and $47,301 was based on NAV.

The redemption terms and notification requirements of the institutional funds range from daily to monthly.

(4) Fair Value Measurements

Meritus measures fair value as the price that would be received to sell an asset or paid to transfer a liability (the exit price) in an orderly transaction between market participants at the measurement date. The accounting guidance outlines a valuation framework and creates a fair value hierarchy in order to increase the consistency and comparability of fair value measurements and the related disclosures. The fair value hierarchy is broken down into three levels based on the source of inputs as follows:

Level I – Quoted prices are available in active markets for identical assets or liabilities as of the report date. A quoted price for an identical asset or liability in an active market provides the most reliable fair value measurement because it is directly observable to the market.

(Continued)

Level II – Pricing inputs are other than quoted prices in active markets, which are either directly or indirectly observable as of the report date. The nature of these securities include investments for which quoted prices are available but traded less frequently and investments that are fair valued using other securities, the parameters of which can be directly observed.

Level III – Securities that have little to no pricing observability as of the report date. These securities are measured using management's best estimate of fair value, where the inputs into the determination of fair value are not observable and require significant management judgment or estimation.

Financial instruments consist of cash equivalents, patient accounts receivable, investments, excluding those accounted for by the equity method, accounts payable and accrued expenses and long-term debt. The carrying amounts reported in the consolidated balance sheets for cash equivalents, patient accounts receivable, and accounts payable and accrued expenses approximate fair value. Management's estimates of other financial instruments are described elsewhere in the notes to the consolidated financial statements.

Meritus does not have any Level 3 financial instruments as of June 30, 2020 and 2019.

Investments are valued using a market approach as follows:

Cash and cash equivalents – Cash equivalents are classified as Level 1 inputs and represent short-term, highly liquid investments that are readily convertible to cash and have original maturities of three months or less.

Stock and equity funds – Common stock and equity funds consist of stock and are valued based upon unadjusted quoted prices in the market.

Mutual Funds – Valued at the closing price reported in the active market in which the mutual fund is traded.

Fixed income bonds – Valued at the closing price reported in the active market in which the bond is traded.

(Continued)

(Dollars in thousands)

The following table presents Meritus' assets measured at fair value on a recurring basis using the market approach, as of June 30:

	Level 1	Level 2	Level 3	Total
2020:				
Cash and cash equivalents	$ 17,957	—	—	17,957
Mutual funds	52,666	—	—	52,666
Certificates of Deposit	66,000	—	—	66,000
Fixed income bonds:				
Corporate debt securities	—	49,444	—	49,444
Mortgage backed securities	—	227	—	227
Asset backed securities	—	2,439	—	2,439
U.S. government notes	—	21,293	—	21,293
Institutional funds:				
Domestic equities	—	39,105	—	39,105
International equities	—	26,735	—	26,735
Fixed income	—	10,660	—	10,660
Total assets	$ 136,623	149,903	—	286,526

	Level 1	Level 2	Level 3	Total
2019:				
Cash and cash equivalents	$ 10,693	—	—	10,693
Mutual funds	90,182	—	—	90,182
Fixed income bonds:				
Corporate debt securities	—	5,384	—	5,384
Mortgage backed securities	—	104	—	104
Asset backed securities	—	2,047	—	2,047
U.S. government notes	—	3,458	—	3,458
Institutional funds:				
Domestic equities	—	33,859	—	33,859
International equities	—	17,906	—	17,906
Fixed income	—	14,240	—	14,240
Total assets	$ 100,875	76,998	—	177,873

There were no Level 3 investments or transfers during the years ended June 30, 2020 and 2019.

(Continued)

(Dollars in thousands)

(5) Property, Plant and Equipment

Property, plant and equipment at June 30 is comprised of the following:

	2020	2019
Land	$ 26,690	26,099
Buildings, and improvements	219,822	218,152
Leasehold Improvements	3,188	3,184
Equipment	196,838	196,263
	446,538	443,698
Less accumulated depreciation and amortization	(219,710)	(200,889)
	226,828	242,809
Construction in progress	8,310	1,799
Property, plant and equipment, net	$ 235,138	244,608

Equipment under finance leases	2020	2019
Equipment	$ —	9,000
Less accumulated amortization	—	(7,120)
	$ —	1,880

Total depreciation and amortization expense for property, plant and equipment for the years ended June 30, 2020 and 2019 was $26,007 and $24,975, respectively.

(6) Equity Investments in Affiliates

The following investments, recorded under the equity method of accounting, are included in the consolidated balance sheets.

The Hospital holds a 25% equity interest in Maryland Care, Inc. ("MPC"), a managed care organization (MCO) that was established to serve Maryland's Medicaid population as a result of the State's requirement for Medicaid patients to be a member of an MCO, and Maryland Care Management, Inc. ("MCMI"), a management services organization that provides management services to MPC.

Holdings holds a 50% interest in General Surgery Real Estate and held a 50% interest in GRI Real Estate it was dissolved on March 31, 2020, both are real estate holding companies. MEI has a 50% interest in Diagnostic Imaging, which provides radiology imaging services.

(Continued)

(Dollars in thousands)

Summary of financial information as of June 30, 2020 and 2019 and for the years then ended appears below for the significant equity investments:

		Maryland Care, Inc.		MEI Diagnostic Imaging Services, LLC	
		2020	2019	2020	2019
Assets	$	390,504	349,769	12,448	10,670
Liabilities		263,567	231,951	5,313	4,027
	Equity $	126,937	117,818	7,135	6,643
Revenue	$	1,102,210	1,097,944	18,853	20,514
Expenses		1,092,280	1,098,169	17,366	19,113
	Net income $	9,930	(225)	1,487	1,401

		Maryland Care Management, Inc.	
		2020	2019
Assets	$	14,202	7,494
Liabilities		2,436	678
	Equity $	11,766	6,816
Revenue	$	14,080	14,203
Expenses		9,316	7,328
	Net income $	4,764	6,875

(Continued)

(Dollars in thousands)

(7) Long-Term Debt

Long-term debt at June 30 consists of the following:

	2020	2019
MHHEFA Revenue Bonds:		
Series 2015 3.50%–5.00% serial bonds, including issue premiums of $12,895	$ 252,970	258,171
City of Hagerstown note	—	20
Mortgages and equipment loans with banks, with interest rates ranging from 2.24% to 7.75%	211	300
Capital lease obligations, with interest rates ranging from 1.76% to 2.30%	—	1,413
	253,181	259,904
Less current portion of long-term debt	(5,481)	(6,644)
Less debt issuance costs and discounts	(1,949)	(2,027)
	$ 245,751	251,233

On July 9, 2015, Meritus issued Series 2015 Bonds to (i) refund all of the Maryland Health and Higher Educational Facilities Authority's Revenue Bonds, Washington County Hospital Issue, Series 2008 (Series 2008 Bonds), and (ii) finance and refinance the cost of construction, renovation and equipping of certain additional facilities for Meritus (the 2015 Project). The Series 2015 Bonds were issued in the principal amount of $257,300 plus a premium of $15,100. The Series 2015 Bonds proceeds, together with the outstanding Series 2008 Bonds escrow fund balance totaled $22,000, and Meritus' internal cash of $7,400 were used to pay the cost of issuance, refund Series 2008 Bonds and receive $20,000 of proceeds for capital expenditures. The Series 2015 Bonds are due in annual principal installments through 2045, and bear interest at 3.5% to 5.0% due semiannually in January and July.

The long-term debt related to the Series 2015 Bonds is reflected in the consolidated financial statements including the unamortized bond premium. The original issue bond premiums are being amortized over the life of the debt and are netted against interest expense in the consolidated statements of operations and changes in net assets.

All bonds are collateralized by a first lien and claims on all receipts of Meritus, except restricted donations and contributions. In connection with the Series 2015 Bonds, the bond holders have a security interest in existing facilities of Meritus. All bonds require the Hospital to maintain certain financial ratios and stipulated insurance coverage as defined.

(Continued)

(Dollars in thousands)

Scheduled principal repayments on long-term debt are as follows for the next five years as of June 30:

2021	$	5,481
2022		5,672
2023		5,867
2024		6,085
2025		6,353
Thereafter		221,774
	$	251,232

(8) Leases Commitments

The company determines if an arrangement contains a lease at the inception of the contract. Right-of-use assets and liabilities are recognized at the contract commencement date for the present value of lease payments over the lease term. The company uses our estimated incremental borrowing rate when no implicit rate is noted within the contract. A right-of-use asset and lease liability was not recognized for leases with an initial term of 12 months or less and rent expense for these types of leases are recognized on a straight-line basis over the lease term, or when incurred if a month-to-month lease.

Meritus utilizes operating leases primarily for real estate, including medical facilities and office space. The real estate lease agreements have initial terms of five to twenty years. Some real estate leases include one or more options to renew, the exercise of lease renewal options is at our sole discretion. When determining the lease term, options to extend or terminate the lease were included when it was reasonably certain the Meritus would exercise that option.

The components of the lease cost and rent expense for the year ended June 30, 2020 are as follows:

Lease cost		**2020**
Operating lease cost:		
Operating lease cost	$	3,715
Short-term lease expense		854
Total operating lease cost	$	4,569

Rent expense under all operating leases was $6,592 for the year ended June 30, 2019.

(Continued)

(Dollars in thousands)

Supplemental balance sheet information related to leases are as follows:

	Balance sheet classification	2020
Operating leases:		
Operating lease ROU assets – current	Prepaid and other current assets	$ 2,379
Operating lease ROU assets – noncurrent	Other assets	16,727
Operating lease ROU liabilities – current	Accounts payable and accrued expenses	2,379
Operating lease ROU liabilities – noncurrent	Other long term liabilities	16,727

Supplemental cash flow and other information related to leases as of and for the year ended June 30, 2020 are as follows:

Other information	2020
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows from operating leases (1)	$ 3,142
Weighted average remaining lease term:	
Operating leases	15 years
Weighted average discount rate:	
Operating leases	4.4 %

(1) Included in other assets and accounts payable, accrued expenses and long-term liabilities in the statement of cash flows.

(Continued)

(Dollars in thousands)

Future maturities of lease liabilities as of June 30, 2020 are as follows:

	Operating leases
Year ending June 30:	
2021	$ 2,978
2022	2,171
2023	1,776
2024	1,654
2025	1,663
Thereafter	16,138
Total minimum lease payments	26,380
Impact of present value discount	(7,274)
Present value of minimum lease payments	$ 19,106

Future minimum lease payments for operating leases and capital leases (with initial or remaining lease terms in excess of one year) as of June 30, 2019 are as follows:

	Operating leases	Capital leases
Year ending June 30:		
2020	$ 2,526	1,428
2021	2,401	—
2022	1,723	—
2023	1,345	—
2024	1,295	—
Thereafter	17,382	—
Total minimum lease payments	$ 26,672	1,428
Less amount representing interest		(14)
Present value of minimum lease payments		$ 1,414

(Continued)

(Dollars in thousands)

(9) Income Taxes

Holdings and its subsidiaries file a consolidated federal return and separate state returns. The income tax (expense) benefit for the years ended June 30, consists of:

	2020	2019
Current:		
Federal	$ (154)	(4)
State	10	(25)
	(144)	(29)
Deferred:		
Federal	(144)	(23)
State	(45)	(7)
	(189)	(30)
	$ (333)	(59)

The significant components of the deferred tax assets and deferred tax liabilities, which are included in prepaid and other current assets and other assets at June 30, are as follows:

	2020	2019
Deferred tax asset:		
Accrued vacation	$ 112	106
Deferred compensation	938	1,093
Allowance for bad debts	31	43
NOL carryover	987	1,071
Fixed assets	118	97
Other	84	41
	2,270	2,451
Deferred tax liabilities:		
Unrealized gain/loss	(17)	(10)
Captive insurance premiums	(9)	(9)
	(26)	(19)
	$ 2,244	2,432

In assessing deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary

(Continued)

differences become deductible. Management considers the scheduled reversal of deferred tax liabilities, projected future taxable income, and tax planning strategies in making this assessment. Based upon positive operation trends through 2020, and projections for future taxable income, management believes that it is more likely than not that the Company will realize the benefits of the deductible differences at June 30, 2020 and 2019. Accordingly, the Company has determined that there is no valuation allowance as of June 30, 2020 and 2019. The amount of the deferred tax asset considered realizable, however, could be reduced in the near term if estimates of future taxable income during the carryforward period are reduced.

As of June 30, 2020 and 2019, the Company has no unrecognized tax benefits. Therefore, the Company does not expect any impact on the effective tax rate related to recognition of unrecognized tax benefits. In addition, there are no anticipated reversals of uncertain tax positions in the next twelve months. The Company's policy is to recognize interest and penalties related to unrecognized tax benefits as a component of income tax expense. As of June 30, 2020 and 2019, the Company has no accrued interest or penalties related to uncertain tax positions.

(10) Post Retirement Benefit Plans

Defined Contribution Plans

Meritus has a 401(k) Savings Plan. The plan is available to all Meritus employees. Meritus matches employee contributions for an amount up to 6% of each employee's base salary, subject to limitations. Amounts charged to expense for the years ended June 30, 2020 and 2019 were $5,931 and $5,675, respectively.

The Hospital has frozen a 403(b) plan. Effective July 1, 2011, the plan was frozen to future contributions.

The Hospital and MEI each maintain an employee funded supplemental nonqualified retirement plan for certain employees. The plan requires the benefits be paid upon termination, retirement or death. The related liability is $6,379 and $6,365 at June 30, 2020 and 2019, respectively. Management has designated investments for the intended purpose of funding the liability when payable.

(11) Insurance Coverage

Meritus has a wholly owned insurance captive, MIC, to provide primary limits of insurance of $1,000 per occurrence/$3,000 aggregate for professional and general liability. In addition, MIC purchased reinsurance from an A rated reinsurer in the amount of $25,000 to cover any potential liabilities above the $1,000/$3,000 primary limits, which were covered by MIC. The self-insured liabilities determined by an actuary for professional and general liability claims are included in other long-term liabilities in the consolidated balance sheets. As of June 30, 2020 and 2019, Meritus recorded a liability of $4,797 and $6,257, respectively.

Consistent with most companies with similar insurance operations, the liability for losses is ultimately based on management's reasonable expectations of future events. It is reasonably possible that the expectations associated with these amounts could change in the near term (i.e., within one year) and that the effect of such changes could be material to the consolidated financial statements.

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In 2020 and 2019, the Company participated in a self-insured plan for workers' compensation claims. Stop-loss coverage has been purchased through a commercial carrier for claims in excess of $300 and not to exceed $700. As of June 30, 2020 and 2019, Meritus recorded a liability of $3,600 and $3,300 respectively, which is included in accrued salaries, wages and withholdings in the consolidated balance sheets.

(12) Risk and Uncertainties

The Company provides general acute healthcare services in the State of Maryland. The Company and other healthcare providers are subject to certain inherent risks, including the following:

- Dependence on revenues derived from reimbursement by the federal Medicare and state Medicaid programs
- Regulation of hospital rates by the State of Maryland Health Services Cost Review Commission
- Government regulation, government budgetary constraints and proposed legislative and regulatory changes, and
- Lawsuits alleging malpractice or other claims

Such inherent risks require the use of certain management estimates in the preparation of the Company's consolidated financial statements and it is reasonably possible that a change in such estimates may occur.

The Medicare and state Medicaid reimbursement programs represent a substantial portion of the Company's revenues and the Company's operations are subject to a variety of other federal, state and local regulatory requirements. Failure to maintain required regulatory approvals and licenses and/or changes in such regulatory requirements could have a significant adverse effect on the Company.

Changes in federal and state reimbursement funding mechanisms and related government budgetary constraints could have a significant adverse effect on the Company.

The federal government and many states have aggressively increased enforcement under Medicare and Medicaid anti-fraud and abuse laws and physician self-referral laws (STARK law and regulation). Federal healthcare reform initiatives continue to prompt a national review of federally funded healthcare programs. In addition, the federal government and many states continue to fund programs to audit and recover potential overpayments to providers from the Medicare and Medicaid programs. The Company has devoted resources to implement a compliance program to monitor conformance with applicable laws and regulations, but the possibility of future government review and enforcement action exists. However, any negative findings from a future proceeding, if any, could result in substantial financial penalties or awards against the Company, exclusion from future participation in the Medicare and Medicaid programs and if criminal proceedings were initiated against the Company, possible criminal penalties. At this time, the Company cannot predict the ultimate outcome of any potential inquiries, or the potential range of damages, if any.

As a result of recently enacted and pending federal healthcare reform legislation, substantial changes are anticipated in the United States healthcare system. Such legislation includes numerous provisions affecting the delivery of healthcare services, the financing of healthcare costs, reimbursement to healthcare

(Continued)

(Dollars in thousands)

providers and the legal obligations of health insurers, providers and employers. These provisions are currently slated to take effect at specified times over the next decade. This federal healthcare reform legislation did not affect the 2020 or 2019 consolidated financial statements.

Litigation

Additionally, Meritus is involved in litigation and regulatory investigations arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without a material adverse effect on Meritus' financial position or results of operations.

(13) Functional Expenses

Meritus provides general healthcare services to residents within its geographic location. Expenses related to providing these services for the years ended June 30 are as follows:

	Program services	General and administrative	Fundraising	Total
2020:				
Salaries and wages	$ 131,312	35,616	—	166,928
Employee benefits	30,258	7,158	—	37,416
Professional fees	13,368	3,153	—	16,521
Supplies and other	110,602	30,473	189	141,264
Interest	8,933	2,270	—	11,203
Depreciation and amortization	21,056	4,951	—	26,007
Total expenses	$ 315,529	83,621	189	399,339

	Program services	General and administrative	Fundraising	Total
2019:				
Salaries and wages	$ 124,607	35,933	—	160,540
Employee benefits	28,889	7,222	—	36,111
Professional fees	12,723	3,181	—	15,904
Supplies and other	122,974	30,743	191	153,908
Interest	9,159	2,290	—	11,449
Depreciation and amortization	19,980	4,995	—	24,975
Total expenses	$ 318,332	84,364	191	402,887

(Continued)

(Dollars in thousands)

(14) Liquidity and Availability of Financial Assets

The following reflects financial assets as of June 30, 2020 and 2019, reduced by amounts not available for general expenditure because of contractual or donor-imposed restrictions within one year.

	2020	2019
Financial assets as of June 30, 2020	$ 404,639	327,858
Less those unavailable for general expenditures within on year, due to:		
Contractual and donor-imposed restriction:		
Funds designated for insurance purpose	(17,589)	(16,470)
Assets held by trustee	(10,691)	(10,577)
Supplemental retirement benefits investment	(6,399)	(5,848)
Donor restricted	(1,145)	(1,144)
Financial assets available within one year to meet cash needs for general expenditures within one year	$ 368,815	293,809

Included in financial assets available are $187,829 and $183,492 of funds set aside for long-term investments as designated by the Board of Directors as of June 30, 2020 and 2019, respectively.

(15) Covid-19

The CARES Act, which was enacted on March 27, 2020, authorizes $100 billion in funding to hospitals and other healthcare providers to be distributed through the Public Health and Social Services Emergency Fund (the "PHSSEF"). Payments from the PHSSEF are intended to compensate healthcare providers for lost revenues and incremental expenses incurred in response to the COVID-19 pandemic and are not required to be repaid provided the recipients attest to and comply with certain terms and conditions, including limitations on balance billing and not using PHSSEF funds to reimburse expenses or losses that other sources are obligated to reimburse. The U.S. Department of Health and Human Services (the "HHS") initially distributed $30 billion of this funding based on each provider's share of total Medicare fee-for-service reimbursement in 2019, but announced that $50 billion in CARES Act funding (including the $30 billion already distributed) will be allocated proportional to providers' share of 2018 net patient revenue. HHS indicated that distributions of the remaining $50 billion were targeted primarily to hospitals in COVID-19 high impact areas, to rural providers, and to reimburse providers for COVID-19-related treatment of uninsured patients. Meritus received approximately $9,956 in payments from the initial PHSSEF payments of which $9,956 were recognized as revenue for the year ended June 30, 2020.

(Continued)

As a way to increase cash flow to Medicare providers impacted by the COVID-19 pandemic, the CARES Act expanded the Medicare Accelerated and Advance Payment Program. Inpatient acute care hospitals may request accelerated payments of up to 100% of the Medicare payment amount for a six-month period (not including Medicare Advantage payments), although CMS is now reevaluating pending and new applications in light of direct payments made available through PHSSEF. CMS based payment amounts for inpatient acute care hospitals on the provider's Medicare fee-for-service reimbursements in the last six months of 2019. Such accelerated payments are interest free for inpatient acute care hospitals for 12 months, and the program currently requires CMS to recoup the payments beginning 120 days after receipt by the provider, by withholding future Medicare fee-for-service payments for claims until the full accelerated payment has been recouped. The program currently requires any outstanding balance remaining after 12 months to be repaid by the provider or be subject to an interest rate currently set at 10.25%. The payments are made for services a healthcare entity has provided or will provide to its Medicare patients who are the healthcare entity's customers. Therefore, they are accounted for under Topic 606 as revenue. In April 2020, Meritus received approximately $66,070 of accelerated payments, which have been accrued on the consolidated balance sheet as of June 30, 2020 as a contract liability and is included in advances from third-party payors, in accordance with ASC 606. This contract liability will be reduced over time as revenue is recognized for claims submitted for services provided after the 120-day period.

Meritus received loan proceeds in the amount of $991 under the Paycheck Protection Program established as part of the CARES Act. As of June 30, 2020, Meritus had reasonable assurance that the conditions of loan forgiveness were met, therefore applying government grant accounting and the loan proceeds were recognized as a reduction in salary expense.

Lastly, the Washington County Health Department granted Meritus $6,000 in CARES Act public health response funding. As of June 30, 2020, the Company had $3,625 in qualified grant expenditures, of which $2,184 was recorded within other operating revenue and $1,441 recorded as a change in net assets in the accompanying statement of operations and changes in net assets.

Due to the recent enactment of the CARES Act and the PPPHCE Act, there is still a high degree of uncertainty surrounding their implementation, and the public health emergency continues to evolve. We continue to assess the potential impact of the CARES Act, the PPPHCE Act, the potential impact of future stimulus measures, if any, and the impact of other laws, regulations, and guidance related to COVID-19 on our business, results of operations, financial condition and cash flows.

(16) Subsequent Events

Meritus evaluated subsequent events through October 2, 2020, the date these consolidated financial statements were available to be issued. All material matters are disclosed in the notes to the consolidated financial statements.

SUPPLEMENTARY INFORMATION

Schedule 1

MERITUS MEDICAL CENTER, INC.

Consolidating Balance Sheet

June 30, 2020

(Dollars in thousands)

	Meritus Medical Center	Meritus Healthcare Foundation	Meritus other	Consolidating total	Consolidating entries	Consolidated total
$	11,998	—	3,563	15,561	—	15,561
	126,524	—	—	126,524	—	126,524
	10,691	—	—	10,691	—	10,691
	27,976	—	3,668	31,644	—	31,644
	5,493	—	854	6,347	—	6,347
	56,908	171	2,874	59,953	(49,475)	10,478
	239,590	171	10,959	250,720	(49,475)	201,245
	185,116	6,845	21,001	212,962	—	212,962
	230,883	—	4,255	235,138	—	235,138
	39,659	—	3,669	43,328	(3,124)	40,204
	21,451	125	5,047	26,623	(2,738)	23,885
$	716,699	7,141	44,931	768,771	(55,337)	713,434

(Continued)

Schedule 1

MERITUS MEDICAL CENTER, INC.

Consolidating Balance Sheet

June 30, 2020

(Dollars in thousands)

l Net Assets	**Meritus Medical Center**	**Meritus Healthcare Foundation**	**Meritus other**	**Consolidating total**	**Consolidating entries**	**Consolidated total**
ed expenses	$ 17,316	66	44,891	62,273	(36,218)	26,055
withholdings	13,239	—	1,515	14,754	—	14,754
fit	10,748	11	3,069	13,828	—	13,828
yors	75,552	—	4,184	79,736	—	79,736
	5,808	—	—	5,808	—	5,808
debt	5,434	—	47	5,481	—	5,481
lities	128,097	77	53,706	181,880	(36,218)	145,662
ortion	245,686	—	65	245,751	—	245,751
	2,972	—	3,407	6,379	—	6,379
	14,639	—	20,148	34,787	(13,257)	21,530
	391,394	77	77,326	468,797	(49,475)	419,322
	—	—	820	820	(820)	—
	—	—	1,150	1,150	(1,150)	—
s' equity	—	—	1,970	1,970	(1,970)	—
	321,390	2,506	(34,365)	289,531	(1,154)	288,377
	3,915	4,558	—	8,473	(2,738)	5,735
	325,305	7,064	(34,365)	298,004	(3,892)	294,112
d net assets	$ 716,699	7,141	44,931	768,771	(55,337)	713,434

t auditors' report.

Schedule 2

MERITUS MEDICAL CENTER, INC.

Consolidating Statement of Operations and Change in Net Assets

Year ended June 30, 2020

(Dollars in thousands)

ıg June 30, 2020	Meritus Medical Center	Meritus Healthcare Foundation	Meritus other	Consolidating total	Consolidating entries	Consolidated total
other support:						
	$ 314,201	—	66,189	380,390	(12,419)	367,971
	23,018	260	2,049	25,327	(3,496)	21,831
	3,517	—	931	4,448	—	4,448
riction used for operations	1,051	712	—	1,763	(630)	1,133
	341,787	972	69,169	411,928	(16,545)	395,383
	129,925	297	36,706	166,928	—	166,928
	30,676	81	6,936	37,693	(277)	37,416
	16,170	—	351	16,521	—	16,521
	113,760	132	42,760	156,652	(15,388)	141,264
	11,197	—	6	11,203	—	11,203
ı	24,664	—	1,343	26,007	—	26,007
	326,392	510	88,102	415,004	(15,665)	399,339
(loss)	15,395	462	(18,933)	(3,076)	(880)	(3,956)
:						
	3,385	117	1,375	4,877	—	4,877
	(64)	(892)	1	(955)	880	(75)
	(46)	—	(287)	(333)	—	(333)
revenue over expenses	$ 18,670	(313)	(17,844)	513	—	513

(Continued)

Schedule 2

MERITUS MEDICAL CENTER, INC.

Consolidating Statement of Operations and Change in Net Assets

Year ended June 30, 2020

(Dollars in thousands)

ling June 30, 2020	Meritus Medical Center	Meritus Healthcare Foundation	Meritus other	Consolidating total	Consolidating entries	Consolidated total
ver expenses	$ 18,670	(313)	(17,844)	513	—	513
	1,178	(253)	(219)	706	(1)	705
e) in unrestricted net assets	19,848	(566)	(18,063)	1,219	(1)	1,218
	790	529	—	1,319	(630)	689
	(1,845)	158	—	(1,687)	1,845	158
ion for operations	(1,051)	(712)	—	(1,763)	630	(1,133)
se restricted net assets	(2,106)	(25)	—	(2,131)	1,845	(286)
e) in net assets	17,742	(591)	(18,063)	(912)	1,844	932
	307,563	7,655	(14,332)	300,886	(7,706)	293,180
	$ 325,305	7,064	(32,395)	299,974	(5,862)	294,112

auditors' report.

KPMG

MERITUS MEDICAL CENTER, INC.

Consolidated Financial Statements and
Supplementary Financial Information

June 30, 2021 and 2020

(With Independent Auditors' Report Thereon)

MERITUS MEDICAL CENTER, INC.

Table of Contents

KPMG LLP
750 East Pratt Street, 18th Floor
Baltimore, MD 21202

Independent Auditors' Report

The Board of Directors
Meritus Medical Center, Inc.:

We have audited the accompanying consolidated financial statements of Meritus Medical Center, Inc. (Meritus), which comprise the consolidated balance sheets as of June 30, 2021 and 2020, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Meritus as of June 30, 2021 and 2020, and the results of its operations and changes in net assets and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Schedules 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

Baltimore, Maryland
October 1, 2021

MERITUS MEDICAL CENTER, INC.

Consolidated Balance Sheets

June 30, 2021 and 2020

(Dollars in thousands)

Assets		2021	2020
Current assets:			
Cash and cash equivalents	$	16,945	15,561
Short-term investments		162,400	126,524
Current portion of assets whose use is limited		10,789	10,691
Accounts receivable		41,133	31,644
Supplies		7,513	6,347
Prepaid and other current assets		11,988	10,478
Total current assets		250,768	201,245
Assets whose use is limited		261,455	212,962
Property, plant and equipment, net		230,951	235,138
Equity investments in affiliates		48,823	40,204
Other assets		24,126	23,885
Total assets	$	816,123	713,434
Liabilities and Net Assets			
Current liabilities:			
Accounts payable and accrued expenses	$	23,298	26,055
Accrued salaries, wages and withholdings		18,143	14,754
Accrued compensation benefit		14,230	13,828
Advances from third-party payors		76,450	79,736
Accrued interest payable		5,710	5,808
Current portion of long-term debt		5,672	5,481
Total current liabilities		143,503	145,662
Long-term debt, net of current portion		240,080	245,751
Accrued retirement benefits		7,005	6,379
Other long-term liabilities		22,549	21,530
Total liabilities		413,137	419,322
Net assets:			
Unrestricted		396,950	288,377
Restricted		6,036	5,735
Total net assets		402,986	294,112
Total liabilities and net assets	$	816,123	713,434

See accompanying notes to consolidated financial statements.

MERITUS MEDICAL CENTER, INC.

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2021 and 2020

(Dollars in thousands)

	2021	2020
Unrestricted revenue, gains and other support:		
Net patient service revenue	$ 448,906	367,971
Other revenue	18,125	21,831
Equity earnings in affiliates	12,662	4,448
Net assets released from restriction used for operations	833	1,133
Total revenues	480,526	395,383
Expenses:		
Salaries and wages	197,289	166,928
Employee benefits	40,991	37,416
Professional fees	17,977	16,521
Supplies and other	124,979	141,264
Interest	10,923	11,203
Depreciation and amortization	25,464	26,007
Total expenses	417,623	399,339
Operating income (losses)	62,903	(3,956)
Nonoperating gains (losses), net:		
Investment returns, net	45,984	4,877
Other, net	(533)	(75)
Income tax expense	(247)	(333)
Excess of revenues over expenses	$ 108,107	513

(Continued)

MERITUS MEDICAL CENTER, INC.

Consolidated Statements of Operations and Changes in Net Assets

Years ended June 30, 2021 and 2020

(Dollars in thousands)

	2021	2020
Unrestricted net assets:		
Excess of revenues over expenses	$ 108,107	513
Other	466	705
Increase in unrestricted net assets	108,573	1,218
Restricted net assets:		
Contributions	723	689
Other	411	158
Net assets released from restriction for operations	(833)	(1,133)
Increase (decrease) in restricted net assets	301	(286)
Increase in net assets	108,874	932
Net assets:		
Beginning of year	294,112	293,180
End of year	$ 402,986	294,112

See accompanying notes to the consolidated financial statements.

MERITUS MEDICAL CENTER, INC.

Consolidated Statements of Cash Flows

Years ended June 30, 2021 and 2020

(Dollars in thousands)

	2021	2020
Cash flows from operating activities:		
Increase in net assets	$ 108,874	932
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	25,464	26,007
Net realized and unrealized gains on investments	(44,502)	(2,949)
(Gain) loss on disposal of assets	(82)	134
Equity earnings in affiliates	(12,662)	(4,448)
Restricted contributions and other	(1,600)	(1,552)
Changes in assets and liabilities:		
Accounts receivable	(9,489)	9,384
Supplies, prepaid, and other current assets	(2,676)	(4,900)
Other assets	(241)	(15,883)
Accounts payable, accrued expenses and long-term liabilities	(1,738)	23,092
Accrued salaries, wages and withholdings	3,389	1,654
Accrued compensation benefit	402	1,410
Advances from third-party payors	(3,286)	66,086
Interest payable	(98)	(120)
Accrued retirement benefits	626	14
Net cash provided by operating activities	62,381	98,861
Cash flows from investing activities:		
Purchase of property, plant and equipment	(21,276)	(17,111)
Proceeds from the disposal of assets	81	440
Purchases of short term investments using advances from third party payors	—	(66,000)
(Purchases) of short-term investments, and assets whose use is limited, net	(39,965)	(28,478)
Equity contributions to affiliates, net	4,043	902
Net cash used in investing activities	(57,117)	(110,247)
Cash flows from financing activities:		
Payments on long-term debt and capital leases	(5,480)	(6,645)
Restricted contributions and other	1,600	1,552
Net cash used in financing activities	(3,880)	(5,093)
Net increase (decrease) in cash and cash equivalents	1,384	(16,479)
Cash and cash equivalents:		
Beginning of year	15,561	32,040
End of year	$ 16,945	15,561
Supplemental disclosure of cash flow information:		
Cash paid for interest	$ 10,923	11,203
Cash paid for income taxes	83	144

See accompanying notes to consolidated financial statements.

(1) Description of Organization

Organization

Meritus Medical Center, Inc. (the Hospital or the Company) is the parent corporation of the Meritus Healthcare Foundation, Inc. (the Foundation), the Meritus Insurance Company, Ltd. (MIC), Meritus Health ACO, LLC (MACO) and Meritus Holdings, LLC (Holdings), which owns Meritus Enterprises (MEI). These entities are collectively referred to as "Meritus".

The Hospital is a not-for-profit acute care hospital located in Hagerstown, Maryland and serves the residents of western Maryland, southern Pennsylvania, and the panhandle of West Virginia. The Hospital currently offers acute general hospital inpatient services, including adult medical/surgical care, obstetrics and newborn care, including a family birthing center, cardiac catheterizations, comprehensive inpatient rehabilitation, radiology and diagnostic services, inpatient and outpatient mental health services, a regional Level III Trauma Center, an intensive care unit, an intermediate care unit, and a pediatric unit. The Hospital also manages gifts, donations or bequests given for the benefit of Meritus and owns real estate properties for rental to medical provider entities and development opportunities.

The Foundation is a not-for-profit corporation whose purpose is to raise philanthropic support for the capital and endowment campaigns of the Hospital. The Foundation also raises money for the Hospital's medical programs, healthcare objectives, scientific research, educational programs, and related community activities. Resources for the Foundation's activities are primarily provided by donors.

MIC is a Cayman Island captive insurance company, wholly owned by the Hospital that provides primary limits of insurance to Meritus for professional liability, employed physician's professional liability, comprehensive general liability, deductible, and stop-loss coverage for health insurance.

As of June 30, 2021, MEI, a for-profit corporation, held ownership interests in the following joint venture:

- Diagnostic Imaging Services, LLC (DIS), an outpatient imaging services provider

Holdings is the sole member of Medical Practices of Antietam, LLC, which employs physicians and operates clinics in the Meritus primary service area.

As of June 30, 2021, Holdings, held ownership interests in the following joint venture:

- General Surgery Real Estate, LLC (GSRE), a real estate holding company

MEI also owns and operates Equipped for Life, a durable medical equipment company (EFL).

MACO is an Accountable Care Organization (ACO), wholly owned by the Hospital. MACO participates in the following CMS programs:

- Medicare Shared Savings Plan ("MSSP"), effective January 1, 2017 through December 31, 2019
- Maryland Primary Care Program ("MDPCP"), as an approved Care Transformation Organization for Washington County, MD, effective January 1, 2019

(Continued)

(2) Summary of Significant Accounting Policies

(a) Principles of Consolidation

The Company's consolidated financial statements include the subsidiaries in which the Company has more than 50% voting interests or when the Company is deemed to have control. Significant intercompany accounts and transactions have been eliminated in consolidation. The accompanying consolidated financial statements include the accounts of the Hospital, Holdings, MEI, the Foundation, MACO, and MIC. All material inter-company balances and transactions have been eliminated in consolidation.

(b) Use of Estimates

The preparation of consolidated financial statements, in conformity with accounting principles generally accepted in the United States of America, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Accordingly, actual results could differ from those estimates.

(c) Cash and Cash Equivalents

Cash and cash equivalents consist of short-term, highly liquid investments that are readily convertible to cash and have original maturities of three months or less. Cash and cash equivalents are carried at cost which approximates fair value.

(d) Patient Accounts Receivable

Patient accounts receivable result from the healthcare services provided by Meritus and are recorded at the net realizable value based on certain assumptions determined by each payor. For third-party payors, including Medicare, Medicaid, and commercial insurance, the net realizable value is based on the estimated contract adjustments, which is based on approved discounts on charges as permitted by the Health Services Cost Review Commission (HSCRC). For self-pay accounts, which included patients who are uninsured and the patient responsibility portion for patients with insurance, the net realizable value is determined using estimates of historical collection experience. See note 2(m) for revenue recognition policies.

(e) Assets Whose Use is Limited

Assets whose use is limited include assets set aside by the Board of Directors for specific purposes, for supplemental retirement benefit investments, to fulfill donor purposes, assets held by trustees under bond indenture agreement, and funds designated for insurance purposes. Amounts required to meet current liabilities are shown as current assets in the consolidated balance sheets. Cash and cash equivalents, as defined above, within assets whose use is limited are treated as investments.

(Continued)

(f) Investments and Investment Income

Investments in equity securities (i.e., investments that have readily determinable fair values and are not accounted for by the equity method) and all investments in debt securities are reported at fair value on the consolidated balance sheets. Institutional funds are recorded at their readily determinable fair values (RDFV). All securities with the exception of alternative investments are reported at fair value. Alternative investments are recorded under the equity method of accounting.

A significant portion of the Meritus' investments are held in an investment portfolio maintained for the benefit of Meritus and its affiliates and its subsidiaries. Investments are classified as trading securities except for certain investments, which are limited or restricted as to use or do not have the liquidity to qualify as trading securities and are classified as investments available for sale.

Investment income and realized gains are recorded as nonoperating revenue. Unrealized gains and losses on trading securities are recorded as nonoperating revenue. Unrealized gains and losses on available for sale investments are included in other changes in net assets. Investment income and realized gains and losses on assets restricted by donors for specific purposes or endowment are included in restricted net assets.

Investment income, which includes interest and dividends, on proceeds of borrowings that are held by a trustee are reported as other revenue. Other investment income, which includes interest, dividends and realized and unrealized gains and losses on assets limited as to use by Board of Directors and funds designated for insurance purposes are recorded as nonoperating gains (losses), net, unless the income or loss is restricted by donor or law.

Meritus' investments are managed by investment managers. Investment securities, in general, are exposed to various risks, such as interest rate, credit and overall market volatility. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near term and that such change could materially affect the amounts reported in the consolidated financial statements.

(g) Supplies

Supplies for the Hospital are carried at cost on a weighted average basis.

(h) Property, Plant and Equipment

Property, plant and equipment acquisitions are recorded at cost. Those assets acquired by gift are carried at amounts established as fair value at the time of acquisition. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Equipment under finance leases are amortized by the straight-line method over the shorter of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the consolidated financial statements. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. No interest was capitalized during the years ended June 30, 2021 and 2020. Leasehold improvements are amortized over the lesser of the useful life or the lease life. Durable medical equipment held for resale is included in supplies. The remainder of durable medical equipment

(Continued)

is rented to patients and is included in property, plant and equipment. Assets are retired or disposed of at book value and related gains or losses are recorded for assets sold. Useful lives range as follows:

Land improvements	5–25 years
Buildings	10–40 years
Equipment	3–20 years
Leasehold improvements	The lesser of the useful life or lease term

Gifts of long-lived assets such as land, buildings, or equipment are reported as other changes in unrestricted net assets unless explicit donor stipulations specify how the donated assets must be used. When applicable, gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long-lived assets must be maintained, expirations of donor restrictions, occur when the donated or acquired long-lived assets are placed into service.

Meritus continually evaluates whether events and circumstances have occurred that indicate the remaining estimated useful life of long-lived assets is appropriate, or whether the remaining balance may not be recoverable. When factors indicate that long-lived assets should be evaluated for possible impairment, Meritus uses an estimate of the related undiscounted operating income over the remaining life of the long lived asset in measuring whether the long-lived asset is recoverable.

The impairment loss on these assets is measured as the excess of the carrying amount of the asset over its fair value. Fair value is based upon market prices, where available, or discounted cash flows. Management believes that no revision to the remaining useful lives is required and there was no impairment of long-lived assets during the years ended June 30, 2021 and 2020.

(i) Deferred Financing Costs

Financing costs incurred in issuing debt have been capitalized and are being amortized over the life of the debt.

(j) Compensated Absences

Meritus records a liability for amounts due to employees for future absences which are attributable to services performed in the current and prior periods. This liability is included in accrued compensation benefit on the consolidated balance sheets.

(k) Restricted Net Assets

Restricted net assets are those whose use by Meritus have been limited by donors to a specific time period or purpose. When donor restrictions expire, that is, when a time restriction ends or a purpose restriction is accomplished, restricted net assets are reclassified into unrestricted net assets and reported as net assets released from restrictions. Restricted net assets also include funds that have been restricted by donors to be maintained by Meritus in perpetuity.

(Continued)

Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions if for operating purposes and as other changes in unrestricted net assets if for capital purposes in the consolidated statements of operations and changes in net assets.

(l) Excess of Revenues over Expenses

The consolidated statements of operations include a performance indicator, the excess of revenue over expenses. Changes in unrestricted net assets that are excluded from the excess of revenues over expenses, consistent with industry practice, include net assets released from restrictions for property, plant and equipment.

(m) Net Patient Service Revenue

For services provided at the Hospital's campus, all payors are required to pay the Maryland Health Services Cost Review Commission (HSCRC) approved rates. The major third-party payors, as recognized by the HSCRC, are allowed discounts of up to 6% on approved rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered.

The Hospital's charges are subject to review and approval by the HSCRC. The total rate of reimbursement for services to patients under the Medicare and Medicaid programs is based on an arrangement between the Centers for Medicare and Medicaid Service and the HSCRC. The Hospital has an agreement with the HSCRC under a rate regulation concept called Global Budget Revenue (GBR) which was renewed as of July 1, 2016 and renews annually. GBR is a revenue constraint methodology which provides for inflation, bad debt, payor differential and adjustments for population growth, but excludes case mix and volume changes. For the years ended June 30, 2021 and 2020, the regulated revenue cap was $437,449 and $396,395, respectively. The Hospital was below its GBR regulated revenue cap in the year ending June 30, 2020 mainly due to the impact of COVID-19 (see note 15). The HSCRC issued regulations due to the impact of COVID-19 on all hospitals in Maryland that allows hospitals to carry over any undercharge less amount recouped from other federal programs to the following fiscal year GBR regulated revenue cap. The regulated revenue cap for the year ending June 30, 2021, includes $24,600 in undercharge carryover from fiscal year 2020.

Services not located on the Hospital's campus and certain other services are not regulated by the HSCRC. Medicare and Medicaid pay the revenues associated with these services based upon established fee schedules. Commercial payors pay at negotiated rates for these services.

Laws and regulations governing the HSCRC, Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Meritus believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action.

Net patient service revenue is recognized, over time, as performance obligations are satisfied. Performance obligations are determined based on the nature of the services provided. Revenue for

(Continued)

(Dollars in thousands)

performance obligations satisfied over time is recognized at the estimated net realizable amounts from patients and third-party payors for services rendered.

The Company generates revenues, primarily by providing healthcare services to its customers. Revenues are recognized when control of the promised good or service is transferred to customers, in an amount that reflects the consideration to which the Company expects to be entitled from patients, third-party payors (including government programs and insurers) and others, in exchange for those goods and services.

The majority of the Company's healthcare services represent a bundle of services that are not capable of being distinct and as such, are treated as a single performance obligation satisfied over time as services are rendered. The Company also provides certain ancillary services which are not included in the bundle of services, and as such, are treated as separate performance obligations satisfied at a point in time, if and when those services are rendered.

The Company's estimate of the transaction price includes estimates of price concessions for such items as contractual allowances, charity care, potential adjustments that may arise from payment and other reviews, and uncollectible amounts, which are determined using a portfolio approach as a practical expedient to account for patient contracts as collective groups rather than individually. Estimates for uncollectible amounts are based on the aging of the accounts receivable, historical collection experience for similar payors and patients, current market conditions, and other relevant factors.

Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to net patient service revenue in the period of the change. Subsequent changes that are determined to be the result of an adverse change in the payor's or patient's ability to pay are recorded as bad debt expense. Bad debt expense for the year ended June 30, 2021 and 2020 was not significant to the consolidated financial statements.

Patient service revenue as a percentage for the years ended June 30, 2021 and 2020, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources based on primary insurance designation, is as follows:

	Third-party	
	2021	**2020**
Net patient service revenue:		
Hospital inpatient	$ 245,616	209,984
Hospital outpatient	184,125	155,736
Other outpatient	180,354	143,862
Gross charges	610,095	509,582
Less contractual and other allowances	(161,189)	(141,611)
Net patient service revenue	$ 448,906	367,971

(Continued)

(n) Charity Care

Meritus provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Meritus does not pursue collection on amounts deemed to qualify as charity. Meritus also estimates that the direct and indirect cost of services and supplies furnished to patients eligible for charity care using a ratio of cost to gross charges based on internal data is $11,394 and $11,889 for the years ended June 30, 2021 and 2020, respectively.

Meritus' patient acceptance policy is based upon its mission statement and its charitable purposes. This policy results in Meritus' assumption of higher-than-normal credit risk from its patients. To the extent that Meritus realizes additional losses resulting from such higher credit risks and clients are not identified or do not meet Meritus' defined charity care policy, such additional losses are recognized as a reduction to net patient service revenue.

Meritus also sponsors certain other charitable programs, which provide substantial benefit to the broader community. Such programs include services to needy and elderly populations that require special support, as well as health and education for the general community welfare. In addition, all other uncollectable amounts resulting from the patients' inability to pay are recorded as a reduction to net patient service revenue, consistent with Meritus' policy.

(o) Other Revenue

Other revenue is comprised of rental income, gains and losses on disposal of assets, grants related to Covid-19 funding including CARES Act funding (see note 14) and other miscellaneous items.

(p) Income Taxes

The Internal Revenue Service has ruled that the Hospital and the Foundation qualify under Section 501(c)(3) of the Internal Revenue Code and are, therefore, not subject to tax under present income tax regulations.

Holdings and MACO are considered a disregarded entity for tax purposes and are reported through the Hospital.

MEI accounts for income taxes through the current recognition of deferred tax liabilities and assets for the expected future tax consequences of temporary differences between tax bases and financial reporting bases of other assets and liabilities.

At present, no income, profit or capital gain taxes are levied in the Cayman Islands and accordingly, no provision for taxation has been made for MIC. In the event that such taxes are levied, MIC has been granted an exemption until September 9, 2023 for any such taxes that might be introduced. MIC intends to conduct its affairs so as not to be liable for taxes in any other jurisdiction.

Meritus follows the accounting guidance for uncertainties in income tax positions, which requires that a tax position be recognized or derecognized based on a "more likely than not" threshold. This applies to positions taken or expected to be taken in a tax return. Meritus does not believe its consolidated financial statements include any material uncertain tax positions. As of June 30, 2021, the Meritus tax years ended June 30, 2016 through June 30, 2021 for federal tax jurisdiction remain open to examination.

(Continued)

(Dollars in thousands)

(q) Concentration of Credit Risk

Meritus invests its excess cash, investments, and assets in financial institutions which are federally insured under the Federal Deposit Insurance Act (FDIA). Deposits in certain accounts exceed federally insured deposit limits. Meritus has experienced no losses on its deposits.

Meritus grants credit without collateral to the patients it serves who primarily live in the tri-state area. The majority of these patients have either insurance through Blue Cross, another insurance company or a health maintenance organization, or qualify for the Maryland Medical Assistance or the Centers for Medicare and Medicaid Services (CMS) programs.

At June 30, Meritus' patient accounts receivable was made up of the following:

	2021	2020
Medical assistance HMO/Medicaid	20 %	22 %
Medicare	35	35
Commercial insurance, HMO and other	25	22
Blue cross/blue shield	12	12
Self-pay	8	9
	100 %	100 %

(r) Deferred Compensation Plan

The Hospital is party to a 457(b) deferred compensation plan and a 457(f) deferred compensation plan, both are intended to provide retirement benefits to certain eligible employees. Assets are deposited with the plan managers, pursuant to this agreement, such that the value of the assets determined by the fair value approximately equals the related accrued deferred compensation liability. The funds are placed into a range of investment strategies from conservative to aggressive. The liability associated with this plan is included in accrued retirement benefits on the consolidated balance sheets.

(s) Management's Assessment and Plans

The Company adopted ASU 2014-5, *Disclosure of Uncertainties about an Entity's Ability to Continue as a Going Concern*, (ASU 2014-15). ASU 2014-15 requires management to evaluate an entity's ability to continue as a going concern within one year after the date that the financial statements are issued (or available to be issued, when applicable). Management determined that there were no conditions or events that raise substantial doubt about the Company's ability to continue as a going concern and the Company will continue to meet its obligations through October 1, 2022.

(t) Leases

In February 2016, FASB issued ASU No. 2016-02, *Leases* (ASU 2016-02). The standard requires Meritus to recognize the assets and liabilities related to leases on the balance sheet. Additionally, in July 2018, FASB issued ASU-2018-11, *Leases* – Targeted Improvements, which provides an additional transition method that would allow entities to not apply the guidance in ASU 2016-02 in the comparative periods presented in the financial statements and instead recognize a cumulative-effect adjustment to the opening balance of retained earnings in the period of adoption. Meritus adopted

(Continued)

(Dollars in thousands)

ASU 2016-02 and its related amendments as of July 1, 2019, using the modified retrospective method applying the transition provisions at the beginning of the period of adoption, rather than at the beginning of the earliest comparative period presented.

Additional lease disclosures can be found in Note 8.

(u) New Accounting Pronouncements

In August 2018, the FASB issued ASU 2018-13, Fair Value Measurements (Topic 820). This ASU improves the effectiveness of the notes to the financial statements through changes in disclosure requirements for fair value measurement. The ASU was adopted effective July 1, 2020 using a retrospective approach. The adoption of the ASU did not have a material impact on the Company's consolidated financial statements.

(3) Investments and Investment Income

Investments at June 30 consisted of the following:

	2021	2020
Short-term investments:		
US government notes	$ 29,146	16,602
Fixed income bonds – corporate	54,591	42,857
Mutual funds	2,199	1,065
Asset backed securities	17,933	—
Certificates of deposit	58,531	66,000
Total	$ 162,400	126,524
Assets whose use is limited:		
Cash and cash equivalents	$ 12,344	17,957
Fixed income:		
Corporate debt securities	6,141	6,587
Mortgage backed securities	295	227
Asset backed securities	2,410	2,439
US government notes	5,981	4,691
Equities:		
Mutual funds	79,019	63,005
Institutional funds:		
Domestic equities	57,725	39,105
International equities	73,628	52,721
Fixed income	21,124	19,897
Alternative investments	13,577	17,024
Total	$ 272,244	223,653

(Continued)

(Dollars in thousands)

The amount of the board designated funds whose use is limited is $234,081 and $187,829 as of June 30, 2021 and 2020, respectively.

Investment returns, net of investments included in the consolidated statements of operations and changes in net assets are comprised of the following for the years ended June 30:

	2021	2020
Investment returns, net:		
Interest and dividends, net of investment fees of $718 and $602 in 2021 and 2020, respectively	$ 1,482	1,928
Net realized gains on investments	6,014	2,381
Change in unrealized gains on investments	38,488	568
	$ 45,984	4,877

At June 30, 2021 and 2020, the Hospital had invested $13,577 and $17,024, or 5% and 7.6%, respectively, of the portfolio in alternative investments, which are invested in hedge funds. The following table summarizes redemption terms for the hedge fund-of-funds vehicles held as of June 30, 2021:

	Fund 1	Fund 2
Redemption timing:		
Redemption frequency	Semi-annually	Monthly
Required notice	95 days	30 days

Additionally, at June 30, 2021 and 2020, the Company has invested in $160,716 and $112,964 of investments and assets whose use is limited for which the value is based on either readily determinable fair value (RDFV) or net asset value (NAV). At June 30, 2021, $86,379 was based on RDFV and $74,337 was based on NAV At June 30, 2020, $49,313 was based on RDFV and $63,651 was based on NAV.

The redemption terms and notification requirements of the institutional funds range from daily to monthly.

(4) Fair Value Measurements

Meritus measures fair value as the price that would be received to sell an asset or paid to transfer a liability (the exit price) in an orderly transaction between market participants at the measurement date. The accounting guidance outlines a valuation framework and creates a fair value hierarchy in order to increase the consistency and comparability of fair value measurements and the related disclosures. The fair value hierarchy is broken down into three levels based on the source of inputs as follows:

Level I – Quoted prices are available in active markets for identical assets or liabilities as of the report date. A quoted price for an identical asset or liability in an active market provides the most reliable fair value measurement because it is directly observable to the market.

(Continued)

Level II – Pricing inputs are other than quoted prices in active markets, which are either directly or indirectly observable as of the report date. The nature of these securities include investments for which quoted prices are available but traded less frequently and investments that are fair valued using other securities, the parameters of which can be directly observed.

Level III – Securities that have little to no pricing observability as of the report date. These securities are measured using management's best estimate of fair value, where the inputs into the determination of fair value are not observable and require significant management judgment or estimation.

Financial instruments consist of cash equivalents, patient accounts receivable, investments, excluding those accounted for by the equity method, accounts payable and accrued expenses and long-term debt. The carrying amounts reported in the consolidated balance sheets for cash equivalents, patient accounts receivable, and accounts payable and accrued expenses approximate fair value. Management's estimates of other financial instruments are described elsewhere in the notes to the consolidated financial statements.

Meritus does not have any Level 3 financial instruments as of June 30, 2021 and 2020.

Investments are valued using a market approach as follows:

Cash and cash equivalents – Cash equivalents are classified as Level 1 inputs and represent short-term, highly liquid investments that are readily convertible to cash and have original maturities of three months or less.

Stock and equity funds – Common stock and equity funds consist of stock and are valued based upon unadjusted quoted prices in the market.

Mutual Funds – Valued at the closing price reported in the active market in which the mutual fund is traded.

Fixed income bonds – Valued at the closing price reported in the active market in which the bond is traded.

(Continued)

(Dollars in thousands)

The following table presents Meritus' assets measured at fair value on a recurring basis using the market approach, as of June 30:

	Level 1	Level 2	Level 3	Total
2021:				
Cash and cash equivalents	$ 12,344	—	—	12,344
Mutual funds	70,146	—	—	70,146
Certificates of deposit	58,531	—	—	58,531
Fixed income bonds:				
Corporate debt securities	—	60,732	—	60,732
Mortgage backed securities	—	295	—	295
Asset backed securities	—	20,343	—	20,343
U.S. government notes	—	35,127	—	35,127
Institutional funds:				
Domestic equities	—	50,509	—	50,509
International equities	—	39,173	—	39,173
Fixed income	—	13,107	—	13,107
Total assets	$ 141,021	219,286	—	360,307

	Level 1	Level 2	Level 3	Total
2020:				
Cash and cash equivalents	$ 17,957	—	—	17,957
Mutual funds	52,666	—	—	52,666
Certificates of deposit	66,000	—	—	66,000
Fixed income bonds:				
Corporate debt securities	—	49,444	—	49,444
Mortgage backed securities	—	227	—	227
Asset backed securities	—	2,439	—	2,439
U.S. government notes	—	21,293	—	21,293
Institutional funds:				
Domestic equities	—	39,105	—	39,105
International equities	—	26,735	—	26,735
Fixed income	—	10,660	—	10,660
Total assets	$ 136,623	149,903	—	286,526

There were no Level 3 investments or transfers during the years ended June 30, 2021 and 2020.

(Continued)

(Dollars in thousands)

(5) Property, Plant and Equipment

Property, plant and equipment at June 30 is comprised of the following:

		2021	2020
Land	$	24,820	26,690
Buildings, and improvements		235,637	219,822
Leasehold improvements		3,601	3,188
Equipment		204,457	196,838
		468,515	446,538
Less accumulated depreciation and amortization		(239,347)	(219,710)
		229,168	226,828
Construction in progress		1,783	8,310
Property, plant and equipment, net	$	230,951	235,138

Total depreciation and amortization expense for property, plant and equipment for the years ended June 30, 2021 and 2020 was $25,464 and $26,007, respectively.

(6) Equity Investments in Affiliates

The following investments, recorded under the equity method of accounting, are included in the consolidated balance sheets.

The Hospital holds a 25% equity interest in Maryland Care, Inc. ("MPC"), a managed care organization (MCO) that was established to serve Maryland's Medicaid population as a result of the State's requirement for Medicaid patients to be a member of an MCO, and Maryland Care Management, Inc. ("MCMI"), a management services organization that provides management services to MPC.

Holdings holds a 50% interest in General Surgery Real Estate and held a 50% interest in GRI Real Estate it was dissolved on March 31, 2020, both are real estate holding companies. MEI has a 50% interest in Diagnostic Imaging, which provides radiology imaging services.

(Continued)

(Dollars in thousands)

Summary of financial information as of June 30, 2021 and 2020 and for the years then ended appears below for the significant equity investments:

		Maryland Care, Inc.		MEI Diagnostic Imaging Services, LLC	
		2021	2020	2021	2020
Assets	$	423,864	390,504	10,868	12,448
Liabilities		247,875	263,567	4,319	5,313
Equity	$	175,989	126,937	6,549	7,135
Revenue	$	1,332,116	1,102,210	20,578	18,853
Expenses		1,288,715	1,092,280	18,804	17,366
Net income	$	43,401	9,930	1,774	1,487

		Maryland Care Management, Inc.	
		2021	2020
Assets	$	15,282	14,202
Liabilities		5,526	2,436
Equity	$	9,756	11,766
Revenue	$	21,552	14,080
Expenses		17,952	9,316
Net income	$	3,600	4,764

(Continued)

(Dollars in thousands)

(7) Long-Term Debt

Long-term debt at June 30 consists of the following:

	2021	2020
MHHEFA Revenue Bonds:		
Series 2015 3.50%–5.00% serial bonds, including issue premiums of $12,303	$ 247,498	252,970
Mortgages and equipment loans with banks, with interest rates ranging from 2.24% to 7.75%	125	211
	247,623	253,181
Less current portion of long-term debt	(5,672)	(5,481)
Less debt issuance costs and discounts	(1,871)	(1,949)
	$ 240,080	245,751

On July 9, 2015, Meritus issued Series 2015 Bonds to (i) refund all of the Maryland Health and Higher Educational Facilities Authority's Revenue Bonds, Washington County Hospital Issue, Series 2008 (Series 2008 Bonds), and (ii) finance and refinance the cost of construction, renovation and equipping of certain additional facilities for Meritus (the 2015 Project). The Series 2015 Bonds were issued in the principal amount of $257,300 plus a premium of $15,100. The Series 2015 Bonds proceeds, together with the outstanding Series 2008 Bonds escrow fund balance totaled $22,000, and Meritus' internal cash of $7,400 were used to pay the cost of issuance, refund Series 2008 Bonds and receive $20,000 of proceeds for capital expenditures. The Series 2015 Bonds are due in annual principal installments through 2045, and bear interest at 3.5% to 5.0% due semiannually in January and July.

The long-term debt related to the Series 2015 Bonds is reflected in the consolidated financial statements including the unamortized bond premium. The original issue bond premiums are being amortized over the life of the debt and are netted against interest expense in the consolidated statements of operations and changes in net assets.

All bonds are collateralized by a first lien and claims on all receipts of Meritus, except restricted donations and contributions. In connection with the Series 2015 Bonds, the bond holders have a security interest in existing facilities of Meritus. All bonds require the Hospital to maintain certain financial ratios and stipulated insurance coverage as defined.

(Continued)

(Dollars in thousands)

Scheduled principal repayments on long-term debt are as follows for the next five years as of June 30:

2022	$	5,672
2023		5,867
2024		6,085
2025		6,353
2026		6,633
Thereafter		215,142
	$	245,752

(8) Leases Commitments

The company determines if an arrangement contains a lease at the inception of the contract. Right-of-use assets and liabilities are recognized at the contract commencement date for the present value of lease payments over the lease term. The company uses our estimated incremental borrowing rate when no implicit rate is noted within the contract. A right-of-use asset and lease liability was not recognized for leases with an initial term of 12 months or less and rent expense for these types of leases are recognized on a straight-line basis over the lease term, or when incurred if a month-to-month lease.

Meritus utilizes operating leases primarily for real estate, including medical facilities and office space. The real estate lease agreements have initial terms of five to twenty years. Some real estate leases include one or more options to renew, the exercise of lease renewal options is at our sole discretion. When determining the lease term, options to extend or terminate the lease were included when it was reasonably certain the Meritus would exercise that option.

Supplemental balance sheet information related to leases are as follows:

	Balance sheet classification		2021
Operating leases:			
Operating lease ROU assets – current	Prepaid and other current assets	$	1,949
Operating lease ROU assets – noncurrent	Other assets		16,966
Operating lease ROU liabilities – current	Accounts payable and accrued expenses		1,949
Operating lease ROU liabilities – noncurrent	Other long term liabilities		16,966

(Continued)

(Dollars in thousands)

Supplemental cash flow and other information related to leases as of and for the year ended June 30, 2021 are as follows:

Other information	2021
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows from operating leases (1)	$ 191
Weighted average remaining lease term:	
Operating leases	14 years
Weighted average discount rate:	
Operating leases	4.4 %

(1) Included in other assets and accounts payable, accrued expenses and long-term liabilities in the statement of cash flows.

Future maturities of lease liabilities as of June 30, 2021 are as follows:

	Leases
Year ending June 30:	
2022	$ 2,723
2023	2,293
2024	2,128
2025	1,953
2026	1,507
Thereafter	15,000
Total minimum lease payments	25,604
Impact of present value discount	(6,689)
Present value of minimum lease payments	$ 18,915

The components of the lease cost and rent expense for the year ended June 30, 2021 are as follows:

Lease cost	2021
Operating lease cost:	
Operating lease cost	$ 3,737
Short-term lease expense	895
Total operating lease cost	$ 4,632

(Continued)

(Dollars in thousands)

(9) Income Taxes

Holdings and its subsidiaries file a consolidated federal return and separate state returns. The income tax (expense) benefit for the years ended June 30, consists of:

	2021	2020
Current:		
Federal	$ (43)	(154)
State	(25)	10
	(68)	(144)
Deferred:		
Federal	(137)	(144)
State	(42)	(45)
	(179)	(189)
	$ (247)	(333)

The significant components of the deferred tax assets and deferred tax liabilities, which are included in prepaid and other current assets and other assets at June 30, are as follows:

	2021	2020
Deferred tax asset:		
Accrued vacation	$ 101	112
Deferred compensation	800	938
Allowance for bad debts	16	31
NOL carryover	1,020	987
Fixed assets	134	118
Other	80	84
	2,151	2,270
Deferred tax liabilities:		
Unrealized gain/loss	(92)	(17)
Captive insurance premiums	(7)	(9)
	(99)	(26)
	$ 2,052	2,244

In assessing deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary

(Continued)

differences become deductible. Management considers the scheduled reversal of deferred tax liabilities, projected future taxable income, and tax planning strategies in making this assessment. Based upon positive operation trends through 2021, and projections for future taxable income, management believes that it is more likely than not that the Company will realize the benefits of the deductible differences at June 30, 2021 and 2020. Accordingly, the Company has determined that there is no valuation allowance as of June 30, 2021 and 2020. The amount of the deferred tax asset considered realizable, however, could be reduced in the near term if estimates of future taxable income during the carryforward period are reduced.

As of June 30, 2021 and 2020, the Company has no unrecognized tax benefits. Therefore, the Company does not expect any impact on the effective tax rate related to recognition of unrecognized tax benefits. In addition, there are no anticipated reversals of uncertain tax positions in the next twelve months. The Company's policy is to recognize interest and penalties related to unrecognized tax benefits as a component of income tax expense. As of June 30, 2021 and 2020, the Company has no accrued interest or penalties related to uncertain tax positions.

(10) Post Retirement Benefit Plans

Defined Contribution Plans

Meritus has a 401(k) Savings Plan. The plan is available to all Meritus employees. Meritus matches employee contributions for an amount up to 6% of each employee's base salary, subject to limitations. Meritus temporarily suspended matching contributions from July 1, 2020 through December 31, 2020. Meritus made a one-time, flat dollar nonelective, employer contribution based on FTE status.

Amounts charged to expense for the years ended June 30, 2021 and 2020 were $3,456 and $5,931, respectively.

The Hospital has frozen a 403(b) plan. Effective July 1, 2011, the plan was frozen to future contributions. On December 31, 2020, the plan was terminated and assets were distributed or rolled-over to participant other retirement accounts.

The Hospital and MEI each maintain an employee funded supplemental nonqualified retirement plan for certain employees. The plan requires the benefits be paid upon termination, retirement or death. The related liability is $7,005 and $6,379 at June 30, 2021 and 2020, respectively. Management has designated investments for the intended purpose of funding the liability when payable.

(11) Insurance Coverage

Meritus has a wholly owned insurance captive, MIC, to provide primary limits of insurance of $1,000 per occurrence/$3,000 aggregate for professional and general liability. In addition, MIC purchased reinsurance from an A rated reinsurer in the amount of $25,000 to cover any potential liabilities above the $1,000/$3,000 primary limits, which were covered by MIC. The self-insured liabilities determined by an actuary for professional and general liability claims are included in other long-term liabilities in the consolidated balance sheets. As of June 30, 2021, and 2020, Meritus recorded a liability of $5,518 and $4,797, respectively.

(Continued)

Consistent with most companies with similar insurance operations, the liability for losses is ultimately based on management's reasonable expectations of future events. It is reasonably possible that the expectations associated with these amounts could change in the near term (i.e., within one year) and that the effect of such changes could be material to the consolidated financial statements.

In 2021 and 2020, the Company participated in a self-insured plan for workers' compensation claims. Stop-loss coverage has been purchased through a commercial carrier for claims in excess of $450. Meritus recorded a liability of $3,600 for the years ended June 30, 2021 and June 30, 2020, which is included in accrued salaries, wages and withholdings in the consolidated balance sheets.

(12) Risk and Uncertainties

The Company provides general acute healthcare services in the State of Maryland. The Company and other healthcare providers are subject to certain inherent risks, including the following:

- Dependence on revenues derived from reimbursement by the federal Medicare and state Medicaid programs
- Regulation of hospital rates by the State of Maryland Health Services Cost Review Commission
- Government regulation, government budgetary constraints and proposed legislative and regulatory changes, and
- Lawsuits alleging malpractice or other claims

Such inherent risks require the use of certain management estimates in the preparation of the Company's consolidated financial statements and it is reasonably possible that a change in such estimates may occur.

The Medicare and state Medicaid reimbursement programs represent a substantial portion of the Company's revenues and the Company's operations are subject to a variety of other federal, state and local regulatory requirements. Failure to maintain required regulatory approvals and licenses and/or changes in such regulatory requirements could have a significant adverse effect on the Company.

Changes in federal and state reimbursement funding mechanisms and related government budgetary constraints could have a significant adverse effect on the Company.

The federal government and many states have aggressively increased enforcement under Medicare and Medicaid anti-fraud and abuse laws and physician self-referral laws (STARK law and regulation). Federal healthcare reform initiatives continue to prompt a national review of federally funded healthcare programs. In addition, the federal government and many states continue to fund programs to audit and recover potential overpayments to providers from the Medicare and Medicaid programs. The Company has devoted resources to implement a compliance program to monitor conformance with applicable laws and regulations, but the possibility of future government review and enforcement action exists. However, any negative findings from a future proceeding, if any, could result in substantial financial penalties or awards against the Company, exclusion from future participation in the Medicare and Medicaid programs and if criminal proceedings were initiated against the Company, possible criminal penalties. At this time, the Company cannot predict the ultimate outcome of any potential inquiries, or the potential range of damages, if any.

(Continued)

(Dollars in thousands)

As a result of recently enacted and pending federal healthcare reform legislation, substantial changes are anticipated in the United States healthcare system. Such legislation includes numerous provisions affecting the delivery of healthcare services, the financing of healthcare costs, reimbursement to healthcare providers and the legal obligations of health insurers, providers and employers. These provisions are currently slated to take effect at specified times over the next decade. This federal healthcare reform legislation did not affect the 2021 or 2020 consolidated financial statements.

Litigation

Additionally, Meritus is involved in litigation and regulatory investigations arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without a material adverse effect on Meritus' financial position or results of operations.

(13) Functional Expenses

Meritus provides general healthcare services to residents within its geographic location. Expenses related to providing these services for the years ended June 30 are as follows:

	Program services	General and administrative	Fundraising	Total
2021:				
Salaries and wages	$ 146,886	50,403	—	197,289
Employee benefits	33,202	7,789	—	40,991
Professional fees	14,624	3,353	—	17,977
Supplies and other	105,497	19,273	209	124,979
Interest	8,579	2,344	—	10,923
Depreciation and amortization	20,302	5,162	—	25,464
Total expenses	$ 329,090	88,324	209	417,623

	Program services	General and administrative	Fundraising	Total
2020:				
Salaries and wages	$ 131,312	35,616	—	166,928
Employee benefits	30,258	7,158	—	37,416
Professional fees	13,368	3,153	—	16,521
Supplies and other	110,602	30,473	189	141,264
Interest	8,933	2,270	—	11,203
Depreciation and amortization	21,056	4,951	—	26,007
Total expenses	$ 315,529	83,621	189	399,339

(Continued)

(Dollars in thousands)

(14) Liquidity and Availability of Financial Assets

The following reflects financial assets as of June 30, 2021 and 2020, reduced by amounts not available for general expenditure because of contractual or donor-imposed restrictions within one year.

	2021	2020
Financial assets as of June 30, 2021	$ 500,098	404,639
Less those unavailable for general expenditures within on year, due to:		
Contractual and donor-imposed restriction:		
Funds designated for insurance purpose	(19,208)	(17,589)
Assets held by trustee	(10,789)	(10,691)
Supplemental retirement benefits investment	(7,022)	(6,399)
Donor restricted	(1,144)	(1,145)
Financial assets available within one year to meet cash needs for general expenditures within one year	$ 461,935	368,815

Included in financial assets available are $234,801 and $187,829 of funds set aside for long-term investments as designated by the Board of Directors as of June 30, 2021 and 2020, respectively.

(15) Covid-19

The CARES Act, which was enacted on March 27, 2020, authorizes $100 billion in funding to hospitals and other healthcare providers to be distributed through the Public Health and Social Services Emergency Fund (the "PHSSEF"). Payments from the PHSSEF are intended to compensate healthcare providers for lost revenues and incremental expenses incurred in response to the COVID-19 pandemic and are not required to be repaid provided the recipients attest to and comply with certain terms and conditions, including limitations on balance billing and not using PHSSEF funds to reimburse expenses or losses that other sources are obligated to reimburse. The U.S. Department of Health and Human Services (the "HHS") initially distributed $30 billion of this funding based on each provider's share of total Medicare fee-for-service reimbursement in 2019, but announced that $50 billion in CARES Act funding (including the $30 billion already distributed) will be allocated proportional to providers' share of 2018 net patient revenue. HHS indicated that distributions of the remaining $50 billion were targeted primarily to hospitals in COVID-19 high impact areas, to rural providers, and to reimburse providers for COVID-19-related treatment of uninsured patients. Meritus received approximately $9,956 in payments from the initial PHSSEF payments of which $9,956 were recognized as revenue for the year ended June 30, 2020. No additional PHSSEF payments were received in the year ended June 30, 2021.

(Continued)

As a way to increase cash flow to Medicare providers impacted by the COVID-19 pandemic, the CARES Act expanded the Medicare Accelerated and Advance Payment Program. Inpatient acute care hospitals may request accelerated payments of up to 100% of the Medicare payment amount for a six-month period (not including Medicare Advantage payments). CMS based payment amounts for inpatient acute care hospitals on the provider's Medicare fee-for-service reimbursements in the last six months of 2019. Such accelerated payments are interest free for inpatient acute care hospitals for 12 months, and the program requires CMS to recoup the payments beginning 12 months after receipt by the provider, by withholding future Medicare fee-for-service payments for claims until the full accelerated payment has been recouped. The program requires any outstanding balance remaining after 17 months to be repaid by the provider or be subject to an interest rate currently set at 4%. The payments are made for services a healthcare entity has provided or will provide to its Medicare patients who are the healthcare entity's customers. In April 2020, Meritus received approximately $66,070 of accelerated payments, which have been accrued on the consolidated balance sheet as of June 30, 2020 as a contract liability and is included in advances from third-party payors, in accordance with ASC 606. As of June 30, 2021, CMS recouped $8,285 of the advance. The accrued contract liability as of June 30, 2021 was $57,785.

Meritus received loan proceeds in the amount of $991 under the Paycheck Protection Program established as part of the CARES Act, primarily for DIS. As of June 30, 2020, Meritus had reasonable assurance that the conditions of loan forgiveness were met, therefore applying government grant accounting and the loan proceeds were recognized as a reduction in salary expense. The loan forgiveness application was accepted as June 30, 2021. No additional draws were received as of June 30, 2021.

Lastly, the Washington County Health Department granted Meritus $6,700 in CARES Act public health response funding. As of June 30, 2021 and 2020, the Company had $3,075 and $3,625 in qualified grant expenditures, of which $2,091 and $2,184 was recorded within other operating revenue and $984 and $1,441 recorded as a change in net assets in the accompanying statement of operations and changes in net assets, respectively.

Due to the recent enactment of the CARES Act and the PPPHCE Act, there is still a high degree of uncertainty surrounding their implementation, and the public health emergency continues to evolve. We continue to assess the potential impact of the CARES Act, the PPPHCE Act, the potential impact of future stimulus measures, if any, and the impact of other laws, regulations, and guidance related to COVID-19 on our business, results of operations, financial condition and cash flows.

(16) Subsequent Events

Meritus evaluated subsequent events through October 1, 2021, the date these consolidated financial statements were available to be issued. All material matters are disclosed in the notes to the consolidated financial statements.

SUPPLEMENTARY INFORMATION

MERITUS MEDICAL CENTER, INC.

Consolidating Balance Sheet

June 30, 2021

(Dollars in thousands)

Assets	Meritus Medical Center	Meritus Healthcare Foundation	Meritus other	Consolidating total
Current assets:				
Cash and cash equivalents	$ 16,607	—	338	16,945
Short-term investments	162,400	—	—	162,400
Current portion of assets whose use is limited	10,789	—	—	10,789
Accounts receivable	37,119	—	4,014	41,133
Supplies	6,571	—	942	7,513
Prepaid and other current assets	69,109	35	5,132	74,276
Total current assets	302,595	35	10,426	313,056
Assets limited as to use	230,837	8,489	22,129	261,455
Property, plant and equipment, net	226,684	—	4,267	230,951
Equity investments in affiliates	48,560	—	3,387	51,947
Other assets	20,577	69	6,123	26,769
Total assets	$ 829,253	8,593	46,332	884,178

MERITUS MEDICAL CENTER, INC.

Consolidating Balance Sheet

June 30, 2021

(Dollars in thousands)

Liabilities and Net Assets	Meritus Medical Center	Meritus Healthcare Foundation	Meritus other	Consolidating total
Current liabilities:				
Accounts payable and accrued expenses	$ 20,915	279	50,117	71,311
Accrued salaries, wages and withholdings	16,555	—	1,588	18,143
Accrued compensation benefit	10,989	—	3,241	14,230
Advances from third party payors	71,589	—	4,861	76,450
Accrued interest payable	5,710	—	—	5,710
Current maturity of long-term debt	5,624	—	48	5,672
Total current liabilities	131,382	279	59,855	191,516
Long term debt, net of current portion	240,064	—	16	240,080
Accrued retirement benefits	4,099	—	2,906	7,005
Other long term liabilities	14,105	—	22,719	36,824
Total liabilities	389,650	279	85,496	475,425
Stockholder's equity:				
Common stock	—	—	820	820
Paid-in capital	—	—	1,150	1,150
Total stockholders' equity	—	—	1,970	1,970
Net assets:				
Unrestricted	435,797	3,441	(41,134)	398,104
Restricted net assets	3,806	4,873	—	8,679
Total net assets	439,603	8,314	(41,134)	406,783
Total liabilities and net assets	$ 829,253	8,593	46,332	884,178

See accompanying independent auditors' report.

MERITUS MEDICAL CENTER, INC.

Consolidating Statement of Operations and Changes in Net Assets

Year ended June 30, 2021

(Dollars in thousands)

Fiscal period ending June 30, 2021	Meritus Medical Center	Meritus Healthcare Foundation	Meritus other	Consolidating total
Unrestricted revenue, gains and other support:				
Net patient revenue	$ 381,605	—	82,116	463,721
Other revenue	17,254	376	3,753	21,383
Equity earnings in affiliates	11,760	—	902	12,662
Net assets released from restriction used for operations	795	551	—	1,346
	411,414	927	86,771	499,112
Operating expenses:				
Salaries and wages	151,313	—	45,976	197,289
Benefits	33,976	—	7,479	41,455
Professional fees	17,587	—	390	17,977
Supplies and other	102,049	185	40,354	142,588
Interest	10,919	—	4	10,923
Depreciation and amortization	24,184	—	1,280	25,464
	340,028	185	95,483	435,696
Operating income (loss)	71,386	742	(8,712)	63,416
Nonoperating gains (losses), net:				
Investment returns, net	42,298	1,643	2,043	45,984
Other, net	(27)	(1,019)	—	(1,046)
Income tax expense	(1)	—	(246)	(247)
Excess (deficit) of revenue over expenses	$ 113,656	1,366	(6,915)	108,107

MERITUS MEDICAL CENTER, INC.

Consolidating Statement of Operations and Changes in Net Assets

Year ended June 30, 2021

(Dollars in thousands)

Fiscal period ending June 30, 2021	Meritus Medical Center	Meritus Healthcare Foundation	Meritus other	Consolidating total
Unrestricted net assets:				
Excess (deficit) of revenues over expenses	$ 113,656	1,366	(6,915)	108,107
Other	752	(432)	146	466
Increase (decrease) in unrestricted net assets	114,408	934	(6,769)	108,573
Restricted net assets:				
Contributions	638	503	—	1,141
Other	47	364	—	411
Net assets released to restriction for operations	(795)	(551)	—	(1,346)
(Decrease) increase restricted net assets	(110)	316	—	206
Increase (decrease) in net assets	114,298	1,250	(6,769)	108,779
Net assets:				
Beginning of year	325,305	7,064	(32,395)	299,974
End of year	$ 439,603	8,314	(39,164)	408,753

See accompanying independent auditors' report.

Joshua Repac

Chief Financial Officer, Meritus Health

Office Phone: 301-790-9351 / Cell Phone: 410-349-7911 / Email: Joshua.repac@meritushealth.com

Professional Experience

Meritus Health Hagerstown, MD
Chief Financial Officer March 2019 – Present

- Meritus is a 327 bed medical center with approximately $500 million of annual operating revenue located in western Maryland.
- Promoted to Chief Financial Officer in July 2021. Previously, was VP of Revenue Cycle and Clinical Support Services where I provided strategic direction to several clinical support service departments.
- Develops, plans, organizes and implements current and future financial management strategies to optimize the financial health of the organization.
  - Helped with the successful transition of revenue cycle management from an MSO back to Meritus
  - Oversaw a 3.5 days accounts receivable reduction over the last 2 years
  - Implemented a strategic business plan to turn around both our home health and DME companies' operating performance
  - Helped identify and implement multiple performance improvement initiatives totaling over $25M
  - Assisted with the HSCRC negotiation to receive an extra $5.1M in GBR revenue for FY 2020
  - Developed a three-year physician investment strategy to meet the needs of the community
  - Awarded $14.3M from FEMA for nursing agency support

Berkeley Research Group Hunt Valley, MD
Director November 2014 – February 2019

- Supervisory, project management and financial analysis skills related to healthcare reimbursement in Maryland and nationally
  - Assisted with the projection and feasibility of multiple Freestanding Medical Facilities
  - Projected the revenue impact of service line deregulation
  - Performed service line contribution margin analyses
  - Performed financial feasibility projections for hospital downsizing
  - Prepared rate requests for additional funding through the HSCRC
  - Assisted with the review of physician billing discrepancies
  - Developed performance improvement targets for health systems

KPMG, LLP Baltimore, MD
Manager Advisory April 2010 – October 2014

- Supervisory, project management and financial analysis skills related to healthcare
- Knowledge and experience in healthcare reimbursement including Maryland HSCRC and Medicare reports, financial projections, regulatory compliance, forecasting, and feasibility studies
  - Prepared Maryland HSCRC and Medicare reports for multiple hospitals
  - Developed GBR and Quality monitoring tools

- Performed monthly regulatory compliance for multiple hospitals
- Assisted in the preparation of a hospital's revenue budget
- Performed gap assessment of ICD-10 preparedness
- Performed a ten-year financial feasibility projection for a billion-dollar healthcare system
- Performed financial feasibility projection for acquisition of a new hospital
- Developed a demand analysis and 5-year financial projection for new regional medical center
- Participated in an RFP preparation and evaluation for selection of a financial information system

KPMG, LLP Baltimore, MD
Senior Associate Auditor July 2007 – March 2010

- Supervised staff for financial statement audits of hospitals and public companies
- Prepared audit reports for A-133 and agreed upon procedures
- Performed financial analysis for acquisitions of physician practices and physician billing companies
- Participated in a hospital bond offering
- Performed a three-year restatement of a public company

Memberships and Affiliations

Board of Directors, Maryland Physicians Care, June 2022 to present

Finance Committee Chair, Horizon Goodwill Industries, 2020 to present

Education

Certified Public Accountant, August 2008
Maryland

Master of Business Administration, May 2007
University of Baltimore/Towson University, Baltimore, MD

Bachelor of Science in Accounting, December 2005
University of Maryland, College Park, MD

University of Baltimore & Towson University

Upon the joint recommendation of the Faculty of
University of Baltimore and Towson University and
by the Authority of the Board of Regents of the University System of Maryland

Joshua Repac

is hereby awarded the degree of

Master of Business Administration

with all rights, honors and privileges thereunto appertaining.
Given under the Universities' seals
this Month of August, two thousand seven.

David H. Nevins
Chairman of the Board of Regents of the University System of Maryland

Robert L. Caret
President of Towson University

W E Kirwan
Chancellor

President of the University of Baltimore

The Board of Regents of the University System of Maryland

University of Maryland

In recognition of the successful completion of the requisite course of study and on nomination of the Faculty of the

Robert H. Smith School of Business

by virtue of authority granted by charter of the State of Maryland hereby confers upon

Joshua Aaron Repac

the degree of

Bachelor of Science

Accounting

with all the honors, rights, and privileges thereunto appertaining.

In witness whereof this Diploma, signed by the authorized officers of the University and sealed with the corporate seal of the University, is granted.

Given at College Park, Maryland, on the twenty-first day of December in the year two thousand five.

UNIVERSITY OF MARYLAND 18 56

David H. Nevins
Chairperson of the Board of Regents of the University System of Maryland

W.E. Kirwan
Chancellor

President

Howard Frank
Dean

11/10/2020 5,592,640

MARYLAND STATE BOARD OF PUBLIC ACCOUNTANCY

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MARYLAND STATE BOARD OF PUBLIC ACCOUNTANCY

CERTIFIES THAT:

JOSHUA AARON REPAC

IS AN AUTHORIZED: **01 - ACTIVE C.P.A.**

LIC/REG/CERT	EXPIRATION	EFFECTIVE	CONTROL NO
37251	11-20-2022	N/A	5592640

Signature of Bearer

Secretary

WHERE REQUIRED BY LAW THIS MUST BE CONSPICUOUSLY DISPLAYED IN OFFICE TO WHICH IT APPLIES

12 01 37251 5,592,640

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MARYLAND STATE BOARD OF PUBLIC ACCOUNTANCY
500 N. CALVERT STREET
BALTIMORE, MD 21202-3651

JOSHUA AARON REPAC
9702 CLYDELEVEN DR

HAGERSTOWN MD 21740

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STATE OF MARYLAND
MARYLAND DEPARTMENT OF LABOR
Lawrence J. Hogan, Jr. Governor
Boyd K. Rutherford Lt. Governor
Tiffany P. Robinson Secretary
MARYLAND STATE BOARD OF PUBLIC ACCOUNTANCY
CERTIFIES THAT:
JOSHUA AARON REPAC
IS AN AUTHORIZED: 01 - ACTIVE C.P.A.
LIC/REG/CERT 37251 EXPIRATION 11-20-2022 EFFECTIVE N/A CONTROL NO 5592640
Signature of Bearer
Secretary